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ICD-10-CM: The Devil Is In the Details

Marc Leib, MD, JD
Chair, ASA Committee on Economics

On August 24, 2015, Sharon Merrick and I presented a webinar on "ICD-10-CM For Anesthesiologists" in which we covered the basic structure of ICD-10-CM codes and provided examples of their use for both surgical anesthesia and the practice of pain medicine. This is now archived on the ASA website and available for viewing at: http://eventcenter.commpartners.com/se/Meetings/Playback.aspx?meeting.id=408595.

At the end of the presentation we opened the lines for questions. One participant asked when to include additional codes beyond the main diagnosis code and how to know when additional codes are required. That question arose when we presented the example of anesthesia for a coronary artery bypass graft in a man with coronary artery disease, unstable angina, hypertension and a history of smoking without current tobacco use. In this example, ICD-10-CM codes include I25.110 (atherosclerotic heart disease of native coronary vessels with unstable angina), I10 (hypertension), and Z87.891 (history of tobacco use).

Selecting codes in this case is relatively straightforward. The main diagnosis is coronary artery disease. The I25 family of codes describes atherosclerotic heart disease. I25.1 denotes atherosclerotic heart disease of native coronary vessel. I25.11 designates atherosclerotic heart disease of native coronary vessel with angina pectoris. Finally, I25.110 defines atherosclerotic heart disease of native coronary vessel with unstable angina pectoris. This is the valid ICD-10-CM code that describes this patient's heart disease. As we explained during the presentation, claims **must** include a valid ICD-10-CM code. A code is valid **only** if it includes all required characters. In this case six characters are required. It is not sufficient to report this condition with I25, I25.1, or I25.11, as these codes do not include all required characters.

The I25 code family includes an instruction to "Use additional code to identify: . . ." followed by a list of six specific conditions, five of which involve current or previous tobacco use. Among those conditions is "history of tobacco use (Z87.891)". The list not only identifies other conditions that must be reported, but also provides specific codes for those conditions. Many cardiovascular and pulmonary codes require a secondary code to describe exposure to tobacco. In each case, the code family

includes an instruction to use an additional code. Anesthesiology practices may want to check with their payers to determine whether the additional code is required for payment.

Many codes include instructions to "Use additional code", "Code also", "Code first", or other similar instructions regarding additional conditions that must be reported. For example:

- G89.-- (pain not elsewhere classified): "Code also related psychological factors associated with pain (F45.42)";
- M81.- (Osteoporosis without current pathological fracture): "Use additional code to identify: major osseous defect, if applicable (M89.7-), personal history of (healed) osteoporosis fracture, if applicable (Z87.310)";
- M46.3- (Infection of intervertebral disc (pyogenic)): "Use additional code (B95-B97) to identify infectious agent";
- M49.-- (Spondylopathies in diseases classified elsewhere): "Code first underlying disease, such as: brucellosis (A23.-); Charcot-Marie-Tooth disease (G60.0); enterobacterial infections (A01-A04); osteitis fibrosa cystica (E21.0)".

As for the diagnosis of hypertension, that is an independent condition that should be included to complete the description of this patient's cardiovascular conditions. Hypertension is reported with code I10, which does not require additional characters. I10 is one of the few three-character codes that are valid on their own.

Additional code families describe hypertensive heart disease (I11), hypertensive chronic kidney disease (I12), hypertensive heart and chronic kidney disease (I13), and secondary hypertension (I15), none of which apply in this case. This illustrates that a number of codes describe common combinations of diseases. When a combination code exists, it should be reported rather than two separate codes.

A number of codes reported by pain medicine physicians are combination codes. For example, in patients with cervical disc disease with radiculopathy, a single code from the M50.1- code section (cervical disc disorder with radiculopathy) describes both the disc disease and the radiculopathy. It is incorrect to report the disc disease and the radiculopathy separately, even though individual codes describe each of these conditions. One of those codes would be used to describe a patient with one, but not both of those conditions. However, if a patient has cervical disc disease with both myelopathy **and** radiculopathy, two separate codes—M50.0- (cervical disc disorder with myelopathy) and M50.1- (cervical disc disorder with radiculopathy)—are necessary to report these conditions because there is no single code that includes both manifestations of the underlying disc disease.

Finally, as we stressed during the webinar, it is not necessary for physicians to understand all the intricacies of code selection. That is up to professional coders who have the necessary training and expertise. However, physicians **must** document all applicable medical conditions so that coders can select the appropriate codes. Incomplete documentation will result in inaccurate coding, which could result in claim denials at the time of adjudication or recoupments during post-payment audits. Proper documentation will facilitate timely claim payment and reduce the chances of post-payment denials. It may also help in risk adjustment, quality, and benchmarking, which may be included in some current or future alternative payment models.