ICD 10 Diagnosis Specificity

Disclaimer:

- This information is provided as a courtesy from *i*Care to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. *i*Care relies upon Forward Health and CMS for payment rules and regulations for claim submission.

As diagnosis codes are used more and more for alternative payment models and to evaluate quality of care, accuracy of coding will become more important.

- Coding specificity includes reporting all diagnosis codes that identify the patient's condition to the highest degree of specificity. Reporting the patient's co-morbidities impacting their current diagnosis will demonstrate the necessity of the level of care provided. The additional diagnosis codes will also support risk-adjustment in any quality measures being considered.

- Not all of the coding guidelines are intuitive and so it is important to understand the specifics of them. The risk with incorrect coding is that it could be identified in an audit and may result in payment corrections

The following are a few areas of the guidelines to consider:

Acute vs. Persistent vs. Recurrent vs. Chronic

- Review the guidelines for how the terms acute, persistent, recurrent, and chronic are defined for various diagnoses. The guidelines define how many episodes within a period of time constitute acute, persistent, recurrent, and chronic. In some cases, a condition that may be thought of in one way may be considered differently by the guidelines.

Example: Diagnosis codes for gastric ulcer include the terms acute and chronic.

- K25 Gastric ulcer
- K25.0 Acute gastric ulcer with hemorrhage
- K25.1 Acute gastric ulcer with perforation
- K25.2 Acute gastric ulcer with both hemorrhage and perforation
- K25.3 Acute gastric ulcer without hemorrhage or perforation
- K25.4 Chronic or unspecified gastric ulcer with hemorrhage
- K25.5 Chronic or unspecified gastric ulcer with perforation
- K25.6 Chronic or unspecified gastric ulcer with both hemorrhage and perforation
- K25.7 Chronic gastric ulcer without hemorrhage or perforation
- K25.9 Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation

Guidelines Cont.

Other Specified vs. Unspecified

- Within a category of codes, it is possible to have an “other specified” or “other” code and an “unspecified” code. These two codes have different meanings. An “other” code means that there are codes for some diagnoses, but there is not one specific for the patient’s condition. In this case, the physician knows what the condition is, but there is no code for it. An “unspecified” code means that the condition is unknown at the time of coding. An “unspecified” diagnosis may be coded more specifically later, if more information is obtained about the patient’s condition.

Example: There are multiple codes for hypothyroidism. If the cause of the patient’s hypothyroidism is known, but is not one of the existing codes, then code E03.8 would be used. If the type of the patient’s hypothyroidism is unknown, code E03.9 would be used.

- E03 Other hypothyroidism
- E03.0 Congenital hypothyroidism with diffuse goiter
- E03.1 Congenital hypothyroidism without goiter
- E03.2 Hypothyroidism due to medicaments and other exogenous substances
- E03.3 Postinfectious hypothyroidism E03.4 Atrophy of thyroid (acquired)
- E03.5 Myxedema coma E03.8 Other specified hypothyroidism
- E03.9 Hypothyroidism, unspecified

Guidelines Cont.

Initial vs. Subsequent

- The concepts of initial encounter vs. subsequent encounter are new in ICD-10. The concepts are only relevant for diagnosis codes for fractures, wounds, sprains, burns, and other general injuries, which are found in Chapters 13 and 19. They are also found in Chapter 20 for external causes of morbidity. A seventh character is used to identify that the encounter is initial or subsequent for the diagnosis code.
  - A - initial encounter
  - D - subsequent encounter
- A subsequent encounter is coded when a patient is seen for follow up care of a condition that previously had a treatment plan and care. An initial encounter is coded when the patient is seen for a new treatment of a condition. It is possible for a patient to be seen at a later point for a condition and have it be an initial encounter, if a new course of treatment is established during that visit.

ICD-10 Facts

Structure of ICD-10-CM

- 3 - 7 characters
- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric •

Characters 3 - 7 are alpha or numeric

- Use of decimal after 3 characters
- Use of dummy placeholder “x”
- Alpha characters are not case-sensitive

ICD 10 Facts Cont.

Specificity Examples

Increased specificity

- S72.044G Nondisplaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing
- I69.351 Sequelae of cerebral infarction, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
- Z47.81 Encounter for orthopedic aftercare following surgical amputation
- Z48.21 Encounter for aftercare following heart transplant

Laterally Examples

- C50.511 Malignant neoplasm of lower-outer quadrant of right female breast
- C50.512 Malignant neoplasm of lower-outer quadrant of left female breast
- C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast

Many errors we see are missing 5th or 6th digits/letters

M40.0 Postural Kyposis - should be greater defined

- M40.00 – site Unspecified
- M40.03 – Cervicothoracic Region
- M40.04 – Thoracis Region
- M40.05 – Thoracolumber Region

R62.5 Other and unspecified lack of expected normal physiological development in childhood – should be greater defined

- R62.50 - Unspecified lack of expected normal physiological development in childhood -
- R62.51 – failure to thrive 9child)
- R62.52 – Short Stature (child)
- R62.59 - Other lack of expected normal physiological development in childhood

Source to verify diagnosis specificity

ICD-10 Coding Book

- https://www.cdc.gov/nchs/icd/icd10cm.htm

Internet Source

- https://www.icd10data.com/

CMS Resources

- MS-DRG Conversion Report http://www.cms.hhs.gov/ICD10/Downloads/MsdrgConversion.pdf
- ICD-10 General Information http://www.cms.hhs.gov/ICD10

iCare Provider Portal Access

- Your time is valuable. *i*Care's Provider Portal allows you to view prior authorizations, service requests, verify eligibility and view claim information for the *i*Care members you serve.

Getting Started

- Registration can be completed with information already at your disposal using your TIN (Tax ID Number), NPI and most recent check number. Use the Facility/Group name as listed on your Explanation of Payment. *i*Care can also generate a one-time PIN, you can request a one-time PIN via the request button below. **If you have checks with more than 20 claims processed your will need to request a PIN to register.**
- If you do not receive your PIN, please contact *i*Care at ProviderRelationsSpecialist@*i*CareHealthPlan.org for additional assistance.
- If an organization chooses to assign roles for the employees, the Office Manager will need to create a user account for the users within your organization. Office Managers can set up additional users individually and invite them to register or you can create user accounts in bulk via spreadsheet upload.
- The ***i*Care Portal User Guide** provides step by step instructions for registration and outlines functionalities. If you have any questions, please contact ProviderOutreach@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.org
- Use care when entering your password in the Provider Portal. If the incorrect password is attempted 3 times, your account will be locked. If you are not able to reset your own password or retrieve your forgotten password, email ProviderOutreach@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.org. Include your Username and your password will be reset within 24 hours.

GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

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Claims/Appeals/Reconsiderations
Local: 414-231-1029
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Eligibility and Provider Services
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