Pearls and Nuggets for ICD-10

Information worth knowing

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The following bits and pieces of useful information for coders and physicians deserve discussion and definition.

"Specificity" in diagnosis coding is the ultimate goal. To achieve the highest specificity, particularly as it pertains to acute injuries, thorough and complete documentation is absolutely necessary. Do not use "Unspecified Codes" or "NOS (Not Otherwise Specified)" simply because they are not "specific." Insurers may not recognize these codes as legitimate, and as such, may not reimburse you for them. Even if the payer does accept them, payment may be reduced. Using these codes instead of very specific codes could cost you money.

If an electronic encounter form is used for the final diagnoses on the claim, the diagnoses have to be supported by the documentation in the records. This would also be consistent with the concept of medical necessity.

Acute injuries and trauma

Documentation for acute injuries and trauma has to be detailed extensively. Fracture coding requires the use of many necessary descriptive terms; open versus closed, displaced versus non-displaced, the fracture pattern, location in the bone (proximal, mid-portion, or distal), and laterality are all necessary. These are particularly important with the initial coding for the fracture.

During the course of follow-up care, the healing status of the fracture has to be adjusted in the code by changes in the seventh character. Because aftercare for fractures is built into the seventh character, the Z codes (Factors Influencing Health Status and Contact with Health Services, Z00-Z99) are not necessary for.

When an injury code is established, particularly as it applies to fractures, the last code, with whichever seventh character is applied, remains with the patient forever. Even if the patient appears to have recovered, but is seen for a problem related to that original injury, albeit several years later, that final injury code has to be reactivated.

When there is a combined injury, such as a bone injury/fracture that extends into a joint, the code applicable to the fracture is given the top priority. Associated injuries of the joint, such as subluxation or dislocation, or ligamentous injuries are coded secondarily in descending order of severity.

In ICD-10, injury codes are regionalized to body sections such as shoulder and upper arm, elbow and forearm, or wrist, hand, and fingers. The sequencing of codes progresses from superficial injuries, such as contusions or abrasions, to open wounds, such as lacerations with or without foreign bodies, then fractures, followed by subluxation and dislocations; sprains; injuries to the nerves; injuries to blood vessels; injuries of muscle, fascia, and/or tendons; crushing injuries; traumatic amputations; and other injuries (which may include epiphyseal fractures when applied to the upper or lower extremities).

In addition to codes for fractures of each bone in the forearm and lower leg, ICD-9 included codes that applied when both bones were fractured. ICD-10 does not have fracture codes that include both bones. Consequently, if both the radius and ulna, or the tibia and fibula, are fractured, each of the two bones has to be coded separately. Although most orthopaedic surgeons may think in terms of the radius and ulna, in ICD-10, fractures of the ulna are coded before fractures of the radius. Fractures in the lower leg include fractures of the patella, the tibia and/or fibula, and the ankle.

Also, in ICD-10, each of the metacarpals has its own code set, as do the phalanges of the thumb and fingers. The same can be said for the metatarsals and phalanges of the foot and toes. In essence, each ray has its own code set. Therefore, if a patient has more than one metacarpal fracture, each has to be coded individually. The same can be said for metatarsals, and phalanges of the toes. This shows how important it is to thoroughly document the records and clinical diagnoses.

In coding extremity injuries, the most severe injury is given the highest priority, followed by any other injuries in decreasing order of severity. Open wounds that are associated with a fracture do not need to be coded separately because they are included in the Gustilo Classification of open fractures, which is indicated by the seventh character. However, other wounds in the same extremity do need to be coded as well.

All joint dislocations are considered "closed" injuries. There are no codes for open dislocations. In case of an open dislocation, the dislocation is coded as closed (seventh character A for the initial encounter, and D or S for subsequent encounters), and another code is added for the open wound with a "foreign body." The dislocated end of the bone is considered to be a foreign body in the soft tissues, since it is outside the joint capsule.

Certain fractures are always considered and coded as "closed." These include torus, greenstick, bent bone, and epiphyseal fractures. The initial encounter code would be A, even if it is an open fracture, and the subsequent encounter codes would be those for closed fractures (D, G, K, P, or S [if there is some other sequela/complication other than delayed healing, nonunion, or malunion]). If any of these fractures are seen in conjunction with a wound that does communicate with the fracture, making it an "open" fracture, another code for the open wound would need to be added.

Osteoporosis

The domain of osteoporosis—primary, secondary, with and without current pathologic fracture, and pathologic fractures—is quite complicated. Primary osteoporosis includes and is synonymous with age-related, involutional, postmenopausal, and/or senile osteoporosis. Secondary osteoporosis includes and is synonymous with medication-induced, "idiopathic," disuse, post-oophorectomy, malabsorption from prior GI surgical procedures, and posttraumatic (Sudeck's atrophy) osteoporosis.

Fractures that may be associated with these forms of osteoporosis include nontraumatic, traumatic (S Codes), and pathologic fractures (secondary to other underlying disease states such as neoplasm, osteomyelitis, osteomalacia, Paget's disease, and osteogenesis imperfecta). Nontraumatic fractures include stress fractures, overuse fractures, wedge compression fracture of the spine, and insufficiency fractures, which may occur without any trauma/injury, or from such a minimal level of trauma that would not ordinarily cause a fracture in normal bone.

Primary osteoporosis, without a current pathologic fracture, is coded in M81.0. Secondary osteoporosis, without a current fracture, is coded to M81.8_, Other Osteoporosis. If the secondary osteoporosis has an underlying cause such as a drug or medication, an additional code for the adverse effect of the drug should be reported. Also, if the patient has a history of fracture from these types of osteoporosis, but no current fracture, and it seems pertinent to the patient's current situation, a code from Z87._, Personal History of, can be added/reported. These codes require only four characters.

Osteoporosis, both primary and secondary, with current pathologic fracture, is coded to M80.0_ (primary) or M80.8_ (secondary). These codes are primarily for extremity fractures, and since these are considered acute/subacute, they must be coded out to seven characters, with the sixth character for laterality, and the seventh character for the encounter.

Spine fractures

Stress, fatigue, wedge compression, and vertebral collapse fractures of the spine are coded to M48.4_ and M48.5_ (spondylopathies). The M48._ codes *exclude* traumatic and pathologic fractures, which should be coded under M80._. Both M48.4 and M48.5 codes require seven characters. If pertinent to the patient's current problem, prior healed stress or pathologic fractures can be coded with the personal history code Z87._.

Pathologic fractures are coded to M84.4_ (not elsewhere classified), M84.5_ (neoplastic disease), and M84.6_ (other disease). Both M84.5 and M84.6 also require coding and reporting of the underlying neoplasm or disease, respectively.

Stress, fatigue, and march fractures of the extremity bones are coded to M84.3_. These require coding to seven characters, along with an external cause code for the activity (Y93).

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marketing materials of nominal value, such as brochures, business cards, or pens.
- However, practices may not provide patient lists to pharmaceutical companies for drug promotions without the patients' authorization.

Don't forget employees

Improper use of health information by a hospital's or medical practice's employees is the second most common cause of a HIPAA data breach and may result in significant fines and penalties. Medical records are worth a lot of money on the black market. Dishonest employees can use medical records for direct personal financial gain (illegally obtaining credit, for example) or can sell them to a third party. Both are egregious HIPAA violations.

To discourage this type of fraud and abuse and minimize its impact, the HIPAA privacy/security officer in each practice should regularly check the logs of employee access to the practice management and EHR systems to look for any abnormal patterns. Any HIPAA violation—security, privacy, or both—can result in substantial fines.

The HIPAA privacy rule comes into play every day in an orthopaedic practice. Administration and enforcement of HIPAA privacy is not overly difficult, but practices must take appropriate steps to ensure proper practice compliance.

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External Cause Codes

Currently, the Centers for Medicare and Medicaid Services has not mandated that External Cause Codes be submitted with claims under a government health plan. However, this could change in the future. Nongovernmental health plans are free to decide whether these codes must be submitted. As a general rule, based on the recommendations of professional coders, it is best to know how to identify and use these codes when filing claims.

External Cause Codes replaced the E Codes of ICD-9. If an External Cause Code requires seven characters, that seventh character will only be A, D, or S. External Cause Codes that do require seven characters, such as Activity Codes beginning with the letter W, must be reported with each claim throughout the course of care and treatment of the patient, along with the appropriate diagnosis code. If an External Cause Code does not have seven characters, it only needs to be reported when filing for the initial evaluation and treatment.

All pertinent External Cause Codes should be submitted with the original claim. These include the main external cause(s), the place of occurrence, the activity, and the status. These codes start with V00 and go through Y99. Place of Occurrence Codes start with Y92; only one Place of Occurrence should be reported, and only on the initial claim. Code Y92.9 is for when the actual place of occurrence is not stated. It should not be used because it is too nonspecific.

Activity Codes are represented by Y93. Only one should be recorded on the medical record, and only with the claim for the initial evaluation and treatment.

Alan Pechacek, MD, is the author of *ICD-10 for Orthopedic Surgery.* This article is excerpted from Appendix B.