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Part B Insider (Multispecialty) Coding Alert

ICD-10: These 3 ICD-10 Answers May Surprise You

Hint: Forget everything you know about ICD-9's 'excludes' codes after next October.

With the ICD-10 transition less than a year away, you may have a handle on how to transition your most frequently-billed diagnoses from ICD-9 to ICD-10. However, if you still have a few questions about the new diagnosis coding system, you aren't alone. CMS and the CDC aim to quell that confusion with several hard-hitting answers that will help you resolve three of your top ICD-10 questions.

1. What If There's No Crosswalk?

With all of the great ICD-9 to ICD-10 crosswalks available, you may wonder whether there are any codes that don't have a bridge between the current coding system and the new one, which will take effect on Oct. 1, 2015. The answer, unfortunately, is yes.

"There are instances where there is not a translation between an ICD-9-CM code and an ICD-10 code," CMS says on its website. "Examples include ICD-10-CM code Y71.3 (Surgical instruments, materials and cardiovascular devices [including sutures] associated with adverse incidents), which has no reasonable translation in ICD-9-CM; and ICD-9-CM procedure code 89.8 (Autopsy), which has no reasonable translation in ICD-10-Procedure Coding System."

As you know, ICD-9 does not advise you to "code close" to a diagnosis code, and ICD-10 won't either. If you can't find an applicable code in ICD-10 that describes your patient's condition, you'll be forced to use an "other" or "unspecified" code and then explain the situation to your MAC if necessary. Reporting an ICD-10 code that's "close" to your patient's condition does everyone a disservice because it brands that patient with a condition he never had, and looks suspicious to auditors who might think you're picking diagnosis codes that get the claim paid but don't actually match the documentation.

In black and white: "Codes titled 'other' or 'other specified" are for use when the information in the medical record provides detail for which a specific code does not exist," the Centers for Disease Control says in its ICD-10-CM Official Guidelines for Coding and Reporting, updated earlier this year. "Codes titled 'unspecified' are for use when the information in the medical record is insufficient to assign a more specific code."

In other words, you'll use an "other specified" code when the doctor is specific in the record but no applicable code exists, and you'll use an "unspecified" code when the physician does not provide you enough information to pinpoint the correct ICD-10 code.

2. Find Your New LCDs

You've almost certainly heard that your payer is going to update its local coverage decisions (LCDs) to reflect which ICD-10 codes are payable with a particular procedure□but where can you find them?

"A list of LCDs converted to ICD-10 is available on the LCDs by Contractor Index," says Part B payer Palmetto GBA on its website. This statement is echoed by the other MACs as well, because each contractor has its own LCD listings that show the payable diagnosis codes.

To get a handle on how to find and interpret the LCDs that include ICD-10 codes on them, check out MLN Matters article SE1421, which was revised on Aug. 4. The document indicates that you can access all LCDs by visiting CMS's coverage database at www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Once you visit that page, click "Indexes" at the top of the page, then click "Local coverage" and pick one of the LCD display options. Then you can check out the LCDs that have an effective date of Oct. 1, 2015□those are the documents that will list ICD-10

codes.

3. Why Are There Two Types of Excludes Notes?

When you browse through the ICD-10 codes, you might see two separate types of "Excludes" notes, which differ from each other in the following ways, the CDC says in ICD-10-CM Official Guidelines for Coding and Reporting: "A type 1 Excludes note is a pure excludes note," the manual says. "It means 'NOT CODED HERE!' An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note." You'll see this used when two conditions can't medically occur together, "such as a congenital form vs. an acquired form of the same condition," the CDC says.

For example: If you look at the Type 1 Diabetes mellitus codes (E10 series), you'll see "Type 1 excludes" followed by a list of conditions that you should not code alongside the E10 codes. These include gestational diabetes (O24.4-) and Type 2 diabetes (E.11-).

The type 2 Excludes note "represents 'Not included here,'" the CDC says in its Guidelines. This means that the condition is separate from what the code includes, even though the patient might have both conditions concurrently. "When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate," the CDC says.

For example: If you look at the dermatitis and eczema section (L20 to L30) in ICD-10, you'll see an Excludes2 note indicating that codes such as perioral dermatitis (L71.0) and dermatitis of eyelid (H01.1-) are excluded from the L20 to L30 series using an Excludes2 note. Therefore, if the patient has both conditions, you can code both.