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MDS Alert

ICD-10 Focus: Check Out These Updates to Relevant ICD-10 Codes

Know these updates to make sure you're recording residents' conditions accurately.

Even though ICD-10 coding may still feel like the anvil that broke the MDS coordinator's back, staying on top of the codes and any changing guidance may be one of the best ways to keep your stress down. The ICD-10 2021 code changes went into effect Oct. 1, 2020, so don't delay in checking out the adjustments, most of which will not necessarily affect skilled nursing facility coding.

The best thing about the 2021 ICD-10-CM changes? "With 490 additions, 58 deletions, and 47 revisions, this year's updates seem very manageable," says **Barbara Hays, CPC, CPCO, CPMA, CRC, CPC-I, CEMC, CFPC,** medical review supervisor, Special Investigations, at GEHA in Lee's Summit, Missouri. "While 490 additions may sound overwhelming, coders and computer programming departments need to realize that 61 of these are V codes describing pedestrian status in an accident."

See How Headache Codes Get New Instructions and More Specificity

One code you will have to unlearn on Oct. 1 will be R51 (Headache) because "coding this common symptom will now require a fourth digit," cautions **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians. You'll now have two choices if your provider records this common symptom: R51.0 (Headache with orthostatic component, not elsewhere classified), which describes headaches that occur while the patient is vertical and are relieved when the resident is horizontal, or R51.9 (Headache, unspecified). Note that this diagnosis is considered Return to Provider for PDPM purposes.

Even more important, the Excludes1 instructions for the R51.- codes have also changed to Excludes2 status. So, the listed conditions - atypical face pain (G50.1), migraine and other headache syndromes (G43-G44), and trigeminal neuralgia (G50.0) - "are no longer considered mutually exclusive to headache. Instead, they become separately reportable in addition to headache when applicable," adds Moore. These three G category diagnosis codes are all considered Medical Management under the Patient-Driven Payment Model (PDPM).

Note These Influenza Coding Changes

You'll also have to adjust your acute upper respiratory infection reporting just in time for flu season and "exercise more caution when using codes in the 'Acute upper respiratory infections' family [J00-J06] if influenza is involved," Moore says. In part, that's because the note that previously appeared at the beginning of the J00-J06 code block has now been deleted and moved to three specific codes in the block.

In other words, the Excludes1 instruction not to report influenza virus with other respiratory manifestations (J09.X2 [Influenza due to identified novel influenza A virus with other respiratory manifestations], J10.1 [Influenza due to other identified influenza virus with other respiratory manifestations], and J11.1 [Influenza due to unidentified influenza virus with other respiratory manifestations]) has been moved to the following codes exclusively:

- J00 (Acute nasopharyngitis [common cold]),
- J02.9 (Acute pharyngitis, unspecified),
- J03.9 (Acute tonsillitis, unspecified), and
- J06 (Acute upper respiratory infections of multiple and unspecified sites).

"This means J09.X2, J10.1, J11.1 are mutually exclusive to the codes under which they are listed. So, if the patient has

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influenza with respiratory manifestations, it would be inappropriate to also classify them as having a common cold [J00],” notes Moore.

"On the other hand, the new instruction to 'Code also' influenza with J04 [Acute laryngitis and tracheitis] and J05 [Acute obstructive laryngitis [croup] and epiglottitis] means you should add an influenza code when appropriate,” says Moore.

While the influenza codes map to Pulmonary, Medical Management, or Acute Infections, the immediately aforementioned four codes are all considered Return to Provider per PDPM.

Add Laterality Characters to Existing Musculoskeletal Codes

"Another area of great importance involves instances where codes are altered to add a fifth or sixth digit to reflect specific body areas and laterality. These should certainly be reviewed, especially if you need to code for anatomical reference,” says Hays.

Nowhere is this truer than the revisions to the M00-M99 (Diseases of the musculoskeletal system and connective tissue) codes. Here, "for the M05-M14 [Inflammatory polyarthropathies] and M19 [Other and unspecified osteoarthritis] groups, ICD-10 is adding new codes to accommodate 'other specified site,' which is otherwise not an option now,” Moore says. One example of this is M06.0A (Rheumatoid arthritis without rheumatoid factor, other specified site).

Note that, in terms of PDPM ICD-10 mapping, codes that are selected to the highest degree of specificity tend to map for paying categories, whereas "unspecified” codes map Return to Provider. One example: The Centers for Medicare & Medicaid Services (CMS) considers M06.872 (Other specified rheumatoid arthritis, left ankle and foot) Non-Surgical Orthopedic/Musculoskeletal, while M06.879 (Other specified rheumatoid arthritis, unspecified ankle and foot) falls into Return to Provider.

Check Big Changes to the J82 Range

Some of the changes to the 2021 code set are the result of stakeholder requests made at last year's ICD-10-CM Coordination and Maintenance Committee (ICMC) Meeting, during which the ICMC's **David Berglund, MD,** offered some insight into the following new code additions.

You'll find a significant expansion of the codes in the J82 (Pulmonary eosinophilia, not elsewhere classified) code range, giving you a fourth character to report, based on the effect of the eosinophilia, as follows:

- J82.81 (Chronic eosinophilic pneumonia)
- J82.82 (Acute eosinophilic pneumonia)
- J82.83 (Eosinophilic asthma)
- J82.89 (Other pulmonary eosinophilia, not elsewhere classified)

"Eosinophilia generally means elevated blood levels of eosinophils, while pulmonary eosinophilia refers to infiltration of eosinophils into the lungs,” Berglund said at the meeting. "There are two types of eosinophilic pneumonia - acute and chronic. While both are characterized by eosinophil invasion of the lung tissue, they are quite different from one another.”

This explains the introduction of the separate codes describing the acute and chronic conditions. In addition, he added, eosinophilic asthma is a leading cause of severe asthma, and can be difficult to treat, making it necessary for codes to describe these specific conditions. "The symptoms of eosinophilic asthma differ from classic asthma and, in fact, more closely resemble those of chronic pulmonary obstructive disorder (COPD),” he noted.

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