Pain Management Coding Alert

ICD-10: Get the Scoop on the Biggest Pain Management Changes Under ICD-10

Tip: Watch individual guidelines and 'excludes' to stay on the right track.

With ICD-10 implementation being delayed until at least October 2015, you have even longer to learn about changes for your specialty and help your providers prepare for a smooth transition. Read on for details on five areas related to pain management that will be changing how you code in some situations.

1. Bilateral Reporting Might Need Multiple Codes

Many diagnoses in ICD-10 specify laterality, such as G56.01 (Carpal tunnel syndrome, right upper limb) and G56.02 (Carpal tunnel syndrome, left upper limb). Others designate that a condition is bilateral (such as M17.0, Bilateral primary osteoarthritis of knee). But how do you handle conditions that are diagnosed as bilateral but don't have a specific code for such?

The solution: You should report two diagnosis codes. According to ICD-10 Coding Guidelines, "If no bilateral code exists and the condition is bilateral, two codes must be assigned (one for right and one for left) to report the complete condition. In the above example, if the pain management provider documented bilateral carpal tunnel syndrome, you would code both the G56.01 and G56.02 ICD-10 codes.

2. Combination Codes Must Fit Circumstances

A combination code in ICD-10 is one that you can report in several instances:

- To classify two diagnoses
- To report a diagnosis with an associated secondary process (manifestation)
- To report a diagnosis with an associated complication.

For example, M50.12 (Cervical disc disorder with radiculopathy, midcervical region) encompasses two diagnoses (cervical disc disorder and radiculopathy). Diagnosis E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy) describes a diagnosis with an associated manifestation.

Coding direction: ICD-10 guidelines state that you should assign only the combination code when the code fully identifies the diagnostic conditions involved or when the Alphabetic Index instructs you to report the condition that way. Do not submit multiple codes when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.

Your providers should clearly indicate the relationship between conditions diagnosed in a patient. Consider documentation of 1) polyneuropathy and 2) Type 2 diabetes versus a single diagnosis of polyneuropathy associated with Type 2 diabetes.

In the first example (polyneuropathy and Type 2 diabetes), the provider doesn't provide the "link" that the polyneuropathy is due to the diabetes. As such, you would report the two conditions as separate diagnoses instead of a combination code. In the second example (polyneuropathy associated with Type 2 diabetes), documentation clearly indicates that the polyneuropathy is a manifestation of the diabetes. That means you would report the conditions as a single combination code.

3. 'Excludes1'and 'Excludes2' Notes Aren't Synonymous

One new feature of ICD-10 is the use of exclusion notes to further help you select the most appropriate diagnosis. ICD-10 includes two categories of exclusion notes.

"Excludes1" is synonymous with "not coded here" and is considered a true exclusion note. The designation is used to indicate that the codes are mutually exclusive. Any code following an Excludes1 notice should never be reported with the code above the Excludes1 note.

Examples: Diagnosis M79.6- (Pain in limb, hand, foot, fingers and toes) has an associated Excludes1 notice of M25.5- (Pain in joint). If the patient is experiencing pain in her right hand and fingers, you won't also report a code from M25.5- designating a painful joint. Diagnosis G43.7 (Chronic migraine without aura) has an Excludes1 of G43.0- (Migraine without aura). You cannot submit G43.7 and G43.0 together because the migraine without aura can't be both "acute" as in G43.0 and "chronic" as in G43.7. Simply report G43.7.

"Excludes2" □ or "not included here" □ means that although the excluded condition is not part of the condition from which it is excluded, there are times when a patient might have both conditions at the same time. If documentation states that both conditions exist together, you should report both.

Example: Consider diagnosis code group M80.- - - - (Osteoporosis with current pathologic fracture) and the associated Excludes2 condition Z87.310 (Personal history of [healed] osteoporosis fracture). If this is the patient's first osteoporotic pathologic fracture, it would not be appropriate to also report the Z87.310 code. If the patient had a previous pathological fracture due to osteoporosis in addition to the current fracture, however, you could report both codes with the ICD-10 code for the current fracture listed as primary.

4. Z Codes Cover Patient Health Status

The Z codes of ICD-10 cover factors influencing health status and contact with health services (Z00-Z99). These codes represent encounters that fall into one of three categories:

- When a person who is not currently sick has a health care encounter for some specific reason
- When a person with a resolving disease, injury, or chronic/long-term condition requiring continuous care has a health care encounter for specific aftercare of that disease or injury
- When circumstances or problems influence a person's health status but are not in themselves a current illness or injury.

Pain management specialists often include diagnosis codes for long-term use of medications or noncompliance with medical treatment. Here's how the current ICD-9 codes will transition under ICD-10:

- V58.69 (Long-term [current] use of other medications) will become Z79.891 (Long term [current] use of opiate analgesic) or Z79.899 (Other long term [current] drug therapy)
- V15.81 (Personal history of noncompliance with medical treatment presenting hazards to health) will shift to Z91.14 (Patient's other noncompliance with medication regimen) or Z91.19 (Patient's noncompliance with other medical treatment and regimen).

Important: When selecting a diagnosis from Z79, remember that codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. You should also assign a code from Z79 if the patient is taking medication for an extended period of time as a prophylactic measure (such as for prevention of deep vein thrombosis) or as treatment for a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer).

Do not report a Z79 code for patients who have addictions to drugs or who use medications for detoxification or maintenance programs while coming off the drug. Also, do not choose a code from Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as antibiotics to treat acute bronchitis).

5. Good Documentation Doesn't Have to Overwhelm

One myth surrounding ICD-10 is that providers will need to document their services in extraordinary detail in order to

report the patient's condition. Many ICD-10 diagnoses are more specific than their ICD-9 predecessors, but providers should already be including those details in their notes for you to code from.

For example, ICD-9 code 337.21 (Reflex sympathetic dystrophy of the upper limb) will offer three options under ICD-10: G90.511 (Complex regional pain syndrome I of right upper limb), G90.512 (Complex regional pain syndrome I of left upper limb), and G90.513 (Complex regional pain syndrome I of upper limb, bilateral). If your provider already designates right, left, or bilateral for patients he currently treats for RSD of the upper limb, you have what you'll need for ICD-10 selection.