Think All ICD-9 Codes Expand Into Multiple Options? Think Again.

Here’s how you should report conditions both acute and chronic.

You may be operating under the assumption that ICD-9 codes will *always* multiply into more specific options, and that’s why the ICD-10-CM manual is so big. However, that isn’t always the case. Conditions requiring two or more ICD-9 codes right now might be simplified into a single ICD-10 option in 2013.

**Best bet:** To determine whether you should report multiple codes or a single ICD-10-CM code, you need to read your coding guidelines. Keep an eye out for phrases like “use additional code” or “code first.”

Capture Single Condition With Multiple Codes

True, you may find that a patient requires multiple ICD-10 codes to fully qualify the condition he or she has.

“**Use additional code:**” When you’re searching the Tabular List, you’ll find “use additional code” notes in situations where you should use a secondary code to fully describe a condition. For instance, you might tack on B95 (*Streptococcus, staphylococcus, and enterococcus*) as a secondary code to identify the bacteria causing the patient’s infection.

“**Code first:**” You might come across “code first” notes in the Alphabetic Index. This means you should code the underlying condition first. For instance, under the B39 (*Histoplasmosis*) category, you’ll see “code first associated AIDS (B20).”

“**Code, if applicable, any causal condition first:**” If you see “Code, if applicable, any causal condition first,” then you may use this code as a principal diagnosis when your physician hasn’t specified the causal condition. If the physician has specified the causal condition, however, then you should code that as the principal diagnosis. For instance, under N13.8 (*Other obstructive and reflux uropathy*), you’ll see “Code first, if applicable, any causal condition, such as enlarged prostate (N40.1).” That means if the provider diagnosed an enlarged prostate, then you would code N40.1 as your principal diagnosis.

Finally, you should be aware that you may need to report multiple codes for late effects, complication codes, and obstetric codes.

**Bonus concept:** Suppose a patient has a condition that is both acute (subacute) and chronic. How should you report this? According to the ICD-10-CM Official Guidelines for Coding and Reporting, you should code both acute (subacute) and chronic. List the acute (subacute) code first. For instance, a patient might have both acute thyroiditis (E06.0) as well as chronic thyoiditis with transient thyrotoxicosis (E06.2). You would report both codes with E06.0 listed first.

Report Multiple Conditions With Single Code

However, rather than code multiple diagnoses for a condition, you may find that ICD-10-CM already has a single code that reflects a combination.
Combination codes (which are a single, unique code) specify:

- Two diagnoses
- A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

Examples: You will find such combinations as I25.110 (Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris), K50.013 (Crohn’s disease of small intestine with fistula), and K71.51 (Toxic liver disease with chronic active hepatitis with ascites).

If you scan the Alphabetic Index, you will find combination codes listed as subterm entries, and you’ll find them specified in the inclusion/exclusion notes in the Tabular List.

Rule: You can only assign a combination code when the physician fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs you.

Don’t use multiple codes when a single combination code clearly identifies all the elements exists.

What should you do when a patient has a complication or manifestation that isn’t listed in a single combination code? That’s when you can use the secondary code(s).

Can You Report Same Diagnosis More Than Once?

You may be wondering if you can report the same diagnosis code more than once, and the answer is no.

In other words, if a patient has two different conditions that a single combination code describes, then you should only report that single combination code once.

Also, this rule applies to bilateral conditions when you don’t have any distinct codes describing laterality. If the condition occurred on both the left and right side and your code states “bilateral,” then you should report that bilateral diagnosis code only once.

Coverage

CMS Is Converting Coverage Decisions to Include ICD-10 Codes

Plus: Medicaid contractors are working to meet ICD-10 deadline.

As of publication date, CMS has not instituted any delay or elimination of ICD-10, which means you’ll need to be ready to use the new code set by Oct. 1, 2013 — less than two years away. Fortunately, medical practices aren’t the only ones working hard to meet the deadline. Contractors, vendors, and individual states are steadily readying their systems for ICD-10 claims processing.

Medicaid: Because Medicaid rules and policies vary on a state-by-state basis, some practices may be expecting states to be on different pages when it comes to ICD-10 implementation. But that would be an inaccurate assumption, CMS reps said during a Nov. 17 “ICD-10 Implementation” call.

“I can tell you that most states are still conducting impact analyses and gathering business requirements for the things needed to accommodate the implementation of ICD-10,” said CMS’s Elizabeth Reed during the call. “CMS currently conducts bi-weekly calls with the states and is currently offering state-specific technical assistance training. I would encourage providers to get on their respective state list serves to stay in tune with state communications and testing requirements,” she added.

Procedure coding: Fortunately, Part B coders won’t have to worry about using the procedural codes, known as ICD-10-PCS, because this code set will only be used for inpatient hospital claims, said CMS’s Pat Brooks during the call.

“ICD-10-PCS will not be used on physician claims, even those for inpatient visits,” Brooks told the callers. In addition, ICD-10 implementation has “no impact on CPT® or HCPCS coding — they will continue to be used as they are now.”

Coverage decisions: One caller to the forum asked whether CMS is working on converting diagnosis codes on the national coverage decisions (NCDs), which are currently listed in ICD-9 format, to ICD-10 codes. Brooks assured the caller that CMS reps are working on such a conversion, but no updates exist on how far along the conversion is at this point.

For more on ICD-10 implementation, visit the CMS Web site at www.cms.gov/ICD10/.

Tools

Get Ready for ICD-10 With These CMS Templates, Planning Assistance

Whether large or small, you’ll find guidance for your practice.

With less than two years to get ready for the diagnosis coding system transition from ICD-9 to ICD-10, your general surgery practice can use all the help you can find.

Now, CMS aims to offer a helping hand in the process with the issuance of several new educational documents.
Take CMS’ Help

On Nov. 9, CMS announced that it had developed four Implementation Handbooks that offer step-by-step instructions for small and medium-sized provider practices, large practices, small hospitals, and payers to seamlessly transition to the new coding system.

In addition to the guidance, CMS offers several templates that can aid your practice during the transition period. For instance,

small and medium practices can use the “Vendor Checklist Case Template” when discussing ICD-10 with their vendors to determine whether the billing systems will be ready for the new diagnosis codes.


Making This “True Crosswalk” Assumption Could Cost You Time and Money

Follow this guide to find out what each flag really means.

You have seen plenty of ICD-9 to ICD-10 bridges online, but beware: these bridges are based on GEMs, which are only about 50-percent accurate. If you rely solely on this mapping tool, you are likely to miss important coding subtleties, which could land your claim in limbo land.

Follow this step-by-step explanation to master GEMs and what each digit really means.

Basics: GEMs stand for General Equivalent Mappings. Note: The important term to remember is “general.”

The GEMs are the raw material from which providers, health information vendors and payers can derive specific applied mappings to meet their needs. You can use GEMs to study the differences between ICD-9-CM and ICD-10-CM/PCS.

The GEM file is a “flat file,” meaning this is a record with no structural relationships. (You can download it here: http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage)

Are GEMs a True Crosswalk?

The word “crosswalk” is often used to refer to code mappings (as in, data element mappings between two distinct data models: ICD-9 and ICD-10), but be advised: GEMs are not true crosswalks. They are reference mappings, to help the user navigate the complexity of translating meaning from one code set to the other. They are tools to help you understand, analyze, and make distinctions that manage the complexity, and to derive their own applied mappings (if that’s your goal).

The GEMs are more complex than a simple one-to-one crosswalk, and some statistics say they’re only about 50-percent accurate. What GEMs are effective at is reflecting the relative complexity of the code sets clearly. The relationship between them is not simple. GEMs effectively demonstrate this, rather than making the transition from the old to the new code system in an oversimplified way.

What are GEMs Relationships Like?

You can have a variety of different code relationships in the GEMs file. Here are a few:

Some codes have a one-to-one correlation. Code 003.21 (Salmonella meningitis) in ICD-9 matches up to A02.21 (Salmonella meningitis) in ICD-10-CM.

Some codes won’t match because of specificity. For instance, 649.53 (Spotting complicating pregnancy) does not, for instance, exactly equal O26.851 (Spotting complicating pregnancy, first trimester). To arrive at the correct code in ICD-10-CM, you have to know the trimester.

Also, ICD-10-CM codes may combine multiple diagnoses or concepts, such as:

- a chronic condition with acute manifestation (G40.911, Epilepsy, unspecified, intractable, with status epilepticus);
- two concurrent acute conditions (R65.21, Severe sepsis with septic shock);
- acute condition with external cause (T39.012A, Poisoning by aspirin, intentional self-harm, initial encounter).

On the other hand, ICD-10-CM code Z72.3 (Lack of physical exercise) doesn’t have a ICD-9 target at all.

(Continued on next page)
So given you can have varied code relationships between the old system and the new, that’s why you can’t count the GEMs file as being cut-and-dried.

What Key Terms Should You Know?

“Target system” means the destination code set. In other words, this is the set the GEM is mapping “to.”

“Source system” means the original code set. In other words, this is the set the GEM is mapping “from.”

When you see your ICD-9-CM code targeting an ICD-10-CM code, then that is called “forward mapping.”

On the other hand, when you see an ICD-10-CM code targeting an ICD-9-CM code, then that is called “backward mapping.”

“Reverse lookup” means that you’re using a GEM by looking at a target system code and examining the codes that translate to it.

What is an Example of a GEM?

Let’s look at the file itself. Here’s an example of what your GEM file looks like.

62130 N8500 00000

In GEM terms, 62130 is your source (which is code 621.30 with your decimal applied); N8500 is your target; and 00000 represents your flags.

**Translation:** This means 621.30 (*Endometrial hyperplasia, unspecified*) maps directly to N8500 (*Endometrial hyperplasia, unspecified*).

How do you know this? Let’s focus on the flags, the ‘00000’ number.

What Do the Flags Mean?

Each digit of the ‘00000’ number represents five different flags.

**Key:** The 0 means off. The 1 means on.

These flags are:

- 1st digit: Approximate Flag
- 2nd digit: No Map Flag
- 3rd digit: Combination Flag
- 4th digit: Scenario Flag
- 5th digit: Choice Flag

Examine the Approximate Flag

“Approximate” is Flag 1, which is in column 1 of the flags. The majority of alternatives are considered an approximate match. “0” means the translation is an identical match. This is rare in the procedure GEMs but more common in the diagnosis GEMs.

Remember this example?

62130 N8500 00000

The first flag is a “0,” meaning you already know that 621.30 has an identical match in N8500.

On the other hand, check out this example:

K3189 5363 10000
K3189 5375 10000
K3189 53789 10000

The first flag is a “1,” means that the complete meaning of the source code differs from the complete meaning of the target system code. In other words, K31.89 (*Other diseases of stomach and duodenum*) includes the meanings of all three codes: 536.3 (*Gastroparesis*), 537.5 (*Gastroptosis*), and 537.89 (*Other specified disorders of stomach and duodenum*). This isn’t a direct match. All of these meanings are approximate.

Find Out What ‘No Map’ Flag Means

“No Map” is Flag 2, which is in column 2 of the flags. A “1” means there is no plausible translation for the source system code. A “0” means there is at least one plausible translation for the source code.

Let’s refer back to our familiar example:

62130 N8500 00000

This means you have at least one plausible translation for the source code. Code 621.30 has a plausible translation in N8500.

However, look at this example:

T500x6A NODX 11000

Because you see a “1” as Flag 2, you can see that T500x6A (*Underdosing of mineralocorticoids and their antagonists, initial encounter*) has no plausible translation. The “NODX” means no description found.

Conquer the Combination Flag

“Combination” is Flag 3, the scenario and choice list flags. When you see a 0 in this position, as in our example, this means the code maps to a single code.

62130 N8500 00000

In other words, 621.30 only maps to N8500.

On the other hand, when you see a 1 in this position, this means the code maps to more than 1 code. Look at this example:

**You Be the Coder**

Refer to N97.8 for Couple’s Infertility Diagnosis

**Question:** What diagnosis code should I use for an office visit where a patient and her husband cannot get pregnant due to the husband’s oligospermia?

**Answer:** See page 7. Ohio Subscriber
Specialty ALERTS

When you start using ICD-10 in 2013, the new code set won’t always offer a simple one-to-one relationship to the old codes. Often, you’ll have additional options that may require tweaking the way your physician documents a service and the way a coder reports it.

(Continued on next page)
Consider this: Under ICD-9, your go-to code for unspecified or other specified non-Hodgkin lymphoma (NHL) is 202.8x (Other lymphomas). So 202.8x serves as both an NEC (not elsewhere classifiable/other specified) and NOS (not otherwise specified/unspecified) code.

**ICD-10 change:** ICD-10 does things a little differently by offering one code range for NHL NEC and another code range for NHL NOS.

**NEC:** ICD-10 2011 includes C85.8- (Other specified types of non-Hodgkin lymphoma) for reporting NHL when the physician documents the type but ICD-10 doesn’t offer a more specific code appropriate for that diagnosis. To start preparing to use this code range, take a close look at the more specific code appropriate for that diagnosis. To start preparing to use this code range, take a close look at the ICD-10 codes available for specified types of NHL. That way, you’ll be able to identify more quickly when the oncologist documents a type that doesn’t match available specific codes. And, just as with ICD-9, be sure to start your ICD-10 code search in the index for terms that match your documentation. That will help you identify the most specific code for your case.

**NOS:** ICD-10 2011 includes C85.9- (Non-Hodgkin lymphoma, unspecified) for use when the oncologist documents NHL without stating the specific type.

**Fifth digit:** The ICD-10 2011 and ICD-9 2011 NHL codes require a fifth digit to be complete. The fifth digit sub-classification is based on the lymph nodes involved. The ICD-10 and ICD-9 options are similar, with one important difference. You will have separate ICD-10 options for unspecified site (0) and extranodal and solid organ sites (9). In ICD-9, the two are both reported using fifth digit 0.

---

**Orthopedics:**

**Pay Attention to Laterality When Reporting Meralgia Paresthetica**

**Key:** ICD-10 has different codes for the right and left limbs.

Meralgia paresthetica may be a diagnosis you encounter frequently in your orthopedic practice; under ICD-10, you’ll need to look specifically for laterality details to accurately code this condition.

Code 355.1 (Meralgia paresthetica) in ICD-9 expands into three options in ICD-10, as of October 1, 2013:

- G57.10 (Meralgia paresthetica, unspecified lower limb)
- G57.11 (Meralgia paresthetica, right lower limb)
- G57.12 (Meralgia paresthetica, left lower limb)

**Understand Meralgia Paresthetica**

Meralgia paresthetica means the patient is experiencing numbness or pain in the outer thigh that is not caused by an injury to the thigh but an injury to the sensory nerve supplying that region. This nerve, called the lateral femoral cutaneous nerve, extends from the spinal column to the thigh. The cause of the numbness or pain is usually an entrapment or compression of the nerve. The pain may be acute and severe and may radiate distantly into the groin or ribs.

**Determine Which Side is Affected**

You’ll choose these codes based on whether the complaints are in the right or left lower limb. You do have an unspecified option, but payers will want you to report to the highest specificity: either right or left. Make sure your orthopedic surgeon clearly specifies which side was affected.

**Documentation:** The provider most likely already documents the patient has meralgia paresthetica in the right or left lower limb, but in ICD-10-CM, you have a new way to reflect that.
**General Surgery:**

5 K38 ICD-10 Codes Expand ICD-9 Appendicitis Specificity

Some conditions get one-to-one crosswalk.

When your surgeon removes an appendix, you’ll have more specific diagnosis code choices under ICD-10, effective Oct. 1, 2013.

Distinguish ‘Other’ and ‘Unspecified’

Coding for acute appendicitis will change as follows, from ICD-9 to ICD-10:

- 540.0 — Acute appendicitis with generalized peritonitis becomes K35.2 with an identical definition
- 540.1 — Acute appendicitis with peritoneal abscess becomes K35.3 (Acute appendicitis with localized peritonitis)
- 540.9 — Acute appendicitis without peritonitis leads to two possible ICD-10 codes: K35.80 (Unspecified acute appendicitis) or K35.89 (Other acute appendicitis).

ICD-10 provides a similar distinction between “other” and “unspecified” for the following ICD-9 to ICD-10 crosswalks:

- 541 — Appendicitis unqualified crosswalks to K37 (Unspecified appendicitis)
- 542 — Other appendicitis crosswalks to K36 (Other appendicitis).

Find More Choices for Other Appendix Conditions

Although you’ll find a one-to-one crosswalk for appendix hyperplasia (543.0, Hyperplasia of appendix [lymphoid] to K38.0, Hyperplasia of appendix), ICD-10 provides many more specific codes for other conditions.

Instead of ICD-9’s 543.9 (Other and unspecified diseases of appendix), you’ll choose one of the following codes starting Oct. 1, 2013:

- K38.1 — Appendicular concretions
- K38.2 — Diverticulum of appendix
- K38.3 — Fistula of appendix
- K38.8 — Other specified diseases of appendix
- K38.9 — Disease of appendix, unspecified.

**Reader Questions**

How to Report Pregnancy Patient Transfers

**Question:**
If a patient transfers out prior to delivery, how should I bill for all visits to date? Should I use a diagnosis other than pregnancy?

**California subscriber**

**Answer:**
For your CPT® code, you’ll have to count the number of visits the ob-gyn saw the patient to determine the correct code. Under CPT® rules, if the ob-gyn saw her only one, two or three times, you bill each as an E/M code (99201-99205 for new patients, 99211-99215 for established patients).

If the ob-gyn saw her four to six times, you bill 59425 (Antepartum care only; 4-6 visits) instead. If the ob-gyn saw her seven or more times before the transfer, you should bill 59426 (… 7 or more visits) instead. But look at what the payer wants because its guidelines may be different from CPT® rules.

Currently, you should use the diagnosis that represents each E/M visit (pregnancy or pregnancy complication), and if billing the series of antepartum visits, add the codes that describe any complications. If none, then use just V22.0 (Supervision of normal first pregnancy) or V22.1 (Supervision of other normal pregnancy).

**ICD-10:** When your diagnosis code system changes, you’ll have new options for those codes mentioned in this article:

Code V22.0 expands into four options: Z34.00 (Encounter for supervision of normal first pregnancy, unspecified trimester), Z34.01 (… first trimester), Z34.02 (… second trimester), Z34.04 (… third trimester).

Code V22.1 will include the four new codes listed above as well as four more: Z34.80 (Encounter for supervision of other normal pregnancy, unspecified trimester), Z34.81 (… first trimester), Z34.82 (… second trimester), and Z34.83 (… third trimester).

**You Be the Coder**

Refer to N97.8 for Couple’s Infertility Diagnosis

**Question on page 4**

**Answer:**
If you’re billing the female patient’s insurance, you should currently report 628.8 (Infertility, female; of other specified origin). This is a “couple” diagnosis, so this is appropriate.

» ICD-10: When your diagnosis coding system changes in 2013, you will report N97.8 (Female infertility of other origin).
The Coding Institute — SPECIALTY ALERTS

Call us: 1-877-912-1691

The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713

The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713
Tel: 1-877-912-1691 Fax: (800) 508-2592 service@codinginstitute.com

I C D - 1 0
C O D I N G   A L E R T

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to ICD-10 coding and reimbursement to the Editor indicated below.

Suzanne Leder, BA, MPhil, CPC, COBGC
suzannel@codinginstitute.com
Editor

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Content Director

The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713
Tel: 1-877-912-1691 Fax: (800) 508-2592 service@codinginstitute.com

ICD-10 Coding Alert is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

CPT® codes, descriptions, and material only are copyright 2012 American Medical Association. All rights reserved. No fee schedules, basic units, relative value units, or related listings are included in CPT®. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Rates: USA: 1 yr. $199. Bulk pricing available upon request. Contact Medallion Specialist Team at medallion@codinginstitute.com. Credit Cards Accepted: Visa, MasterCard, American Express, Discover

This program has the prior approval of AAPC for 0.5 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor. Log onto Supercoder.com/membersarea to access CEU quiz.

To request log in information, e-mail service@codinginstitute.com

Order or Renew Your Subscription!

☐ Yes! Enter my: one-year subscription (12 issues) to ICD-10 Coding Alert for just $199.
☐ Extend! I already subscribe. Extend my subscription for one year for just $199.

E-mail ______________________

* Must provide e-mail address for online option to receive issue notifications

Name ______________________
Title ______________________
Company ______________________
Address ______________________
City, State, ZIP ______________________
Phone ______________________
Fax ______________________
E-mail ______________________

ICD-10 Coding Alert
The Coding Institute
PO Box 933729
Atlanta, GA 31193-3792
Call 1-877-912-1691
Fax (801) 705-3942
E-mail: service@codinginstitute.com

SuperCoder.com
Inscribed by Coders, Powered by Coding Experts

SuperCoder is a property of CodingInstitute.com

Payment Options
Charge my: ☐ MasterCard ☐ VISA ☐ AMEX ☐ Discover

Card # ______________________
Exp. Date: / /
Signature: ______________________

☐ Check enclosed
☐ Bill me (please add $15 processing fee for all billed orders)

ICT-10 Coding Alert
The Coding Institute
PO Box 933729
Atlanta, GA 31193-3792
Call 1-877-912-1691
Fax (801) 705-3942
E-mail: service@codinginstitute.com

SuperCoder.com
Inspired by Coders, Powered by Coding Experts

SuperCoder is a property of CodingInstitute.com

Specialty specific codesets, tools and content on one page in SuperCoder.com. Call 1-866-228-9252 now for a super deal!

Single User Copy: Not allowed for more than one user without Publisher Approval