HNS
ICD-10 Important Facts & Coding Guidelines
(Revised 10/01/17)

1. Basics:

ICD-10:

- Consists of 3 to 7 characters
- First character is alpha
- Second, third, fourth, and fifth characters are numeric
- Always at least three characters
- Decimal is placed after the first three characters
- Alpha characters are not case sensitive

2. Structure

Characters 1-3 indicate the category of the diagnosis.
Characters 4-6 indicate etiology, anatomic site, severity or other clinical detail.
Character 7 = extension.

The following example shows the detailed information gained through the added characters:

S52 Fracture of forearm
S52.5 Fracture of lower end of radius
S52.52 Torus fracture of lower end of radius
S52.521 Torus fracture of lower end of right radius
S52.521A Torus fracture of lower end of right radius, initial encounter

In the example above, S52 is the category. The 4th and 5th characters of "5" and "2" provide additional clinical detail and anatomic site. The 6th character "1" indicates laterality, i.e., right radius. The 7th character "A" is an extension which, in this example, means "initial encounter".

3. Number of Characters

- A valid code is one that is carried out to the highest number of characters available.
- Valid codes may be 3 to 7 characters in length.
- The diagnosis must be coded to the absolute highest level for that code, meaning the maximum number of characters for the code being used.
- When they are available for assignment in the code set, sixth and seventh characters are not optional; they must be used.

4. Hierarchy

The acute condition should always be listed first.

- Neurological diagnosis
- Structural descriptor diagnosis
- Functional diagnosis
- Soft tissue
- Extremity
- Complicating factors

Code each health care encounter to the level of certainty known for that encounter.

Codes selected for use must be fully supported by documentation in the healthcare record.

Code all documented conditions that coexist at the time of the visit that ***require or affect*** patient care. (Do not code conditions that no longer exist.)

An external cause code can never be a principal (first-listed) diagnosis.

5. Specificity

Always code to the highest level of specificity.

Codes that describe symptoms and signs are acceptable ONLY if they represent the highest level of diagnostic certainty documented by the doctor.

As a general rule, codes that describe symptoms, such as low back pain, lumbalgia, cervicalgia, etc., should not be listed as the principal diagnosis, but, as applicable, should be listed secondary to a structural diagnosis.

In ICD-10, there are a plethora of codes that are considered non-specific. These are typically identified with wording such as "*not otherwise specified*" or "*not elsewhere classified*." Be wary of using these codes!

Many payors will deny chiropractic services reported with unspecified codes.

If you are not familiar with a payor, prior to the submission of a claim, contact the payor to determine what, if any, specificity requirements are used in the adjudication process, relative to chiropractic services.

Diagnoses that are probable, suspected, likely or questionable should not be reported.

Unspecified codes should ONLY be reported when they most accurately reflect what is known about the patient's condition at the time of that particular encounter and when they are consistent with the documentation in the healthcare record.

6. Chapter 13 (M Codes) Diseases of the Musculoskeletal System and Connective Tissue.

Many of the codes within this chapter have site and laterality designations.

Segmental Dysfunction Codes

For commercial claims, the ICD-9 739 codes have been replaced with the ICD-10 "M" codes. For ICD-9 diagnoses of 739.0-739.8, use ICD-10 M99.00- M99.08 codes.

7. Chapter 19 (S Codes) Injury, Poisoning and Certain Other Consequences of External Causes

Replaces the ICD-9 "800" series of codes.

Injuries are grouped by body part rather than category of injuries as they were in ICD-9.

Most codes in this category require the 7th character extension, either A, D or S. (See additional information below on the 7th character extension.)

8. External Cause Codes

HNS providers are not required to report external cause codes, although physicians are strongly encouraged to do so because the codes provide valuable data research and evaluation of injury prevention strategies.

If you choose to report an external cause code, it is important to note that you must not submit an external cause code by itself; it always must have a corresponding **principal diagnosis code.** (An external cause code can never be a principal (first-listed) diagnosis.)

There are four different types of external cause codes. Each code answers one of the following questions:

- How did the injury or condition happen?
- Where did it happen?
- What was the patient doing when it happened?
- Was it intentional or unintentional?

External cause codes define the manner of the injury, the mechanism, the place of occurrence of the event, the activity, and the status of the person at the time

the injury occurred.

- Manner refers to whether the cause of injury was unintentional/accidental, self-inflicted, assault, or undetermined.
- Mechanism describes how the injury occurred such as a motor vehicle accident, fall, contact with a sharp object or power tool, or being caught between moving objects.
- Place identifies where the injury occurred, such as a personal residence, playground, street, or place of employment.
- Activity indicates the activity of the person at the time the injury occurred such as swimming, running, bathing or cooking.
- External cause status is used to indicate the work or non-work status of the person at the time death or injury occurred such as work done for pay, military activity, volunteer activity, or leisure activity.

You may assign as many external cause codes as necessary to explain the patient's condition to the fullest extent possible. As a general rule, you only need to report external cause codes for the initial encounter. Typically, you would only report place of occurrence, activity, and external cause status codes during your initial evaluation of the patient. However, there are a handful of codes – particularly ones that describe how an injury happened – that you can report more than once. These codes are usually ones that require a seventh character designating the encounter type (e.g., A, D, or S).

If you submit multiple external cause codes for a single diagnosis code, you should order them according to significance. In other words, the first cause code you list should be the one that describes the cause or intent most closely related to the principal diagnosis.

9. Laterality

Laterality (side of the body affected) is required for many ICD-10 codes. If a code requires laterality it must be included in order for the code to be valid.

- The number 1 is used to indicate right side.
- The number 2 is used to indicate left side.
- The number 3 indicates bilateral.
- The number 9 indicates side is unspecified in the medical records (For extremity-related and certain other diagnoses, "0" may be required rather than "9".)

10. 7th Character Extensions

7th character extensions are found predominantly in two chapters of the ICD-10-CM/PCS, Chapter 19 - which includes the "S" codes, and also in Chapter 15 (Pregnancy, Childbirth and the Puerperium). The information below addresses the use of the 7th character for codes found in Chapter 19.

One of the following seventh characters must be assigned to codes in the "S" category to provide information about the episode of care. CMS has provided

the following information regarding episodes of care:

"A" (Initial encounter) - Initial encounter is defined as the period when the patient is receiving active treatment for the injury, poisoning, or other consequences of an external cause. An "A" may be assigned on more than one claim.

"D" (Subsequent encounter) - An encounter after the active phase of treatment and when the patient is receiving routine care for the injury during the period of healing or recovery.

"S" (Sequela) - Complications that arise as a direct result of a condition.

When to Use "S" (Sequela) -
7th character "S", sequela, is for use for complications that arise as a direct result of a condition.

When using 7th character "S", it is necessary to use **both** the injury code that precipitated the sequela and the code for the sequela itself. **The "S" is added only to the injury code**, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela is sequenced first, followed by the injury code.

11. Placeholders

ICD-10 utilizes a placeholder, which is always the letter "X". Placeholders must be used when a code has less than six characters and a seventh character is required. The "X" is assigned for all characters less than six in order to meet the requirement of coding to the highest level of specificity.

Examples:
(These examples assume the visit would be coded as "initial encounter".)

S23.41xA (Sprain of ribs)
S33.5xxA (Sprain of lumbar region)

12. Choosing the ICD-10 Code

Don't Forget the HNS Code Translator. The HNS Code Translator is a list of the top 100 ICD-9 diagnoses (reported the most frequently by HNS Providers) and the possible corresponding ICD-10 codes. The Translator is available on the HNS website.