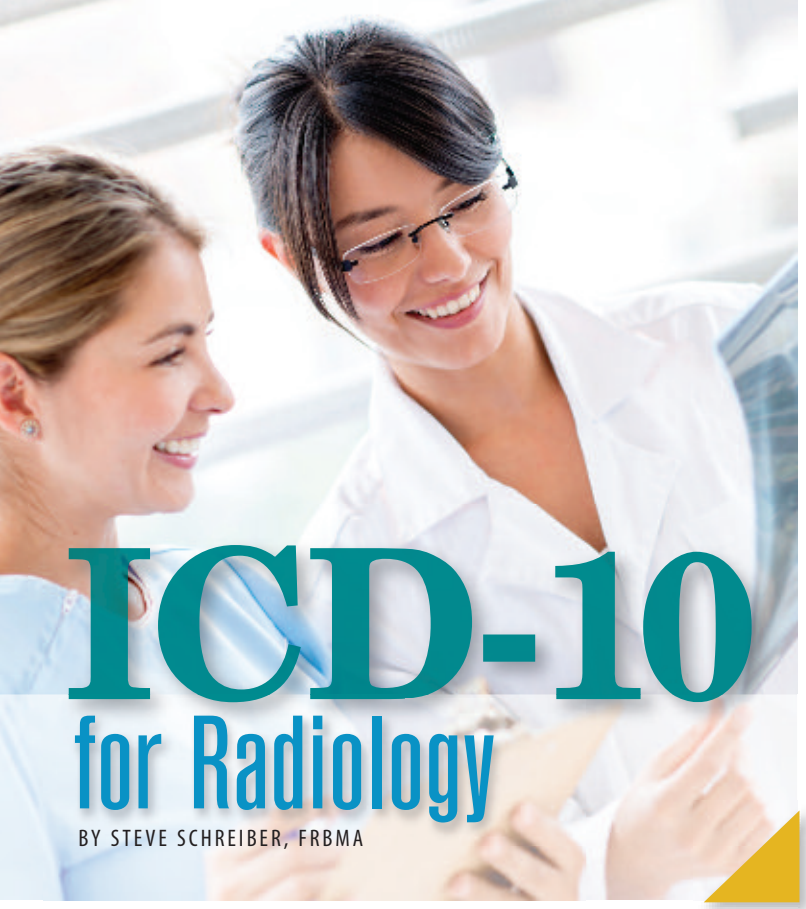

ICD-10 for Radiology

BY STEVE SCHREIBER, FRBMA

There has already been a lot written about ICD-10 implementation. We now know that the Federal government has delayed implementation for another year to October 2015. The rest of the developed nations have already complied with the World Health Organization's need to collect and analyze healthcare information. And while this is an honorable goal many of us fear that 3rd party payors will use this event as another opportunity to somehow delay or reduce payment to providers.

While the pressure is off, many of us will be using this time to continue to make progress to make sure that we are fully prepared for the eventuality. In our case we will be reviewing radiologist's reports to determine if the final report includes the necessary language to properly code in the ICD-10 world.

As my years of experience and vested interest center around radiology, I would like to focus this editorial on impacts to this battered medical specialty. Radiology practices are highly dependent on intake information obtained by a hospital partner, or referring practitioner. The radiologist and their teams (receptionists, schedulers, billers, coders, technologists, and administrators) have to pay extra close attention to the information at the front end of the workflow process to avoid backend delays, hassles, and reduced revenues.

Coders know that a potential for fraud exists if codes are applied that are not supported by the radiologist's report. Increasingly asking a coder or biller to contact a referring physician for additional clinical information after the patient left will result in poor customer relations with referring clinicians and their staff. Everyone needs to address this on the front end of the patient process.

So, how do I know that this is a real issue for radiology? I did my homework and reviewed the top 50 diagnosis codes used in 2013 by radiology practice clients. This is an exercise that I recommend all radiology administrators perform. Here are some examples of what I found.

Example 1: Five percent of all patients seen in 2013 had a diagnosis of 789.09. There are three new codes to replace this code.

ICD-9 Code	ICD-10 Codes
789.09* Abdominal pain other specified site	R10.10 Upper abdominal pain, unspecified R10.2 Pelvic and perineal pain R10.30 Lower abdominal pain, unspecified

Example 2: Another practice had only a few 786.09 codes used. There are 5 new codes to replace this one. Will the report provide the pertinent information?

ICD-9 Code	ICD-10 Codes
786.09 Respiratory abnormal NEC	R06.00 Dyspnea, unspecified R06.09 Other forms of dyspnea R06.3 Periodic breathing R06.83 Snoring R06.89 Other abnormalities of breathing

Example 3: Almost six percent of patients seen in 2013 had headaches as a diagnosis. This may be an easy fix with only two codes to select from.

ICD-9 Code	ICD-10 Codes
784.0 Headache	G44.1 Vascular headache, not elsewhere classified R51 Headache

Example 4: The nightmare! Seven percent of all patients seen in this practice in 2013 had a diagnosis of 729.5 pain in limb. In ICD-10 there are 30 more detailed codes that describe where the pain is located. Let's make sure that the radiologist report is specific enough!

ICD-9 Code	ICD-10 Codes
729.5 Pain in Limb	M79.601 Pain in right arm M79.602 Pain in left arm M79.603 Pain in arm, unspecified M79.604 Pain in right leg M79.605 Pain in left leg M79.606 Pain in leg, unspecified M79.609 Pain in unspecified limb M79.621 Pain in right upper arm M79.622 Pain in left upper arm M79.629 Pain in unspecified upper arm M79.631 Pain in right forearm M79.632 Pain in left forearm M79.639 Pain in unspecified forearm M79.641 Pain in right hand M79.642 Pain in left hand M79.643 Pain in unspecified hand M79.644 Pain in right finger(s) M79.645 Pain in left finger(s) M79.651 Pain in right thigh M79.652 Pain in left thigh M79.659 Pain in unspecified thigh M79.661 Pain in right lower leg M79.662 Pain in left lower leg M79.669 Pain in unspecified lower leg M79.671 Pain in right foot M79.672 Pain in left foot M79.673 Pain in unspecified foot M79.674 Pain in right toe(s) M79.675 Pain in left toe(s) M79.676 Pain in unspecified toe(s)

Example 5: Life is not all bad! There is a one-to-one mapping for unspecific abdominal pain. What a relief that is!

ICD-9 Code	ICD-10 Codes
789.00 Abdominal pain unspecified	R10.9 Unspecified abdominal pain

Example #5 above contains the use of "unspecified" which is an especially important concept for radiology. According to CMS:

> *"If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing to determine a more specific code."*

Hopefully, it goes without saying that educating your scheduling team is vital to this process. Yes, they are under tremendous pressure to quickly get the information and get off the phone. That said, recognizing when the need for specific anatomic site, etiology, and severity will help them to continue to quickly gather necessary information.

In my own personal experience I know that a great deal of clinical information regarding patient signs and symptoms is obtained by the technologist while escorting the patient from the waiting room or positioning the patient in the exam room. Hopefully, that information is being included in the technologist notes in the RIS/PACS system and being referenced by the radiologist in their report.

Now, imagine the power of giving this information to your radiologists as part of the practice preparedness. This awareness will allow them to include the new necessary information in their reports. Equally, they can then incorporate needed clinical information when they are on the phone for a pre-exam consult. Finally, this should be part of radiologist conversations when participating in lunch and learns at referring offices.

As your practice prepares for this, I would suggest including your hospital partner in the process. Most radiology practices today have access to much greater and more granular information that can be of real benefit. Wouldn't it be great for the radiologist to go to a hospital partner and say that they can provide the names of all referring physicians over the past year, what imaging services were ordered at the hospital, the most frequently used ICD-9 diagnosis codes that were apply to imaging services (verses hospital admission), and what additional clinical information pertinent to that individual referring physicians patients will be needed under ICD-10. That is true value added services that hospitals will have a very difficult time assembling themselves.

The real unknown for me is on the third party payor side of the equation. We already know that the denial process can run high for "not medically necessary" reasons. In the beginning there is great risk of payors not fully mapping procedures with new allowed diagnosis reasons. For this reason alone I would highly recommend that practices be prepared for increased denials resulting in short term reduced revenues. Including the corporate controller, CFO, or billing manager in watching cash deposits should be part of any radiology practice plan. Establishing a healthy line of credit with your bank may be a life saver.

Each practice should assess how this change in diagnosis coding applies to them. Then determine what work processes should be modified to facilitate successful implementation of this new detail and educate your team on the necessary changes. Positive education and teamwork now will diminish punitive repercussions later.

STEVE SCHREIBER, FRBMA
is the chief operating officer for Affiliated Radiologists. He has over 22 years of medical practice management experience with the emphasis being in radiology, and has managed hospital-based and combined hospital/imaging center practices in highly competitive environments. He has been an active member of RBMA, previously serving on the board of directors, as Vendor Relations committee chair, and as a member of various other committees. *Steve can be reached at sschreiber@prodigy.net or 312-563-4275.*