CPT CODING UPDATE FOR 2015

NERVES

Presented by
Susan Carbone, MBA, CPC, MCS-P
Evaluation and Management Services
and
John F. Bishop, PA, CPMA, CPC, CGSC, CPRC
Director of Surgical Services
The Coding Network, LLC

THE NUMBERS ARE IN!

- 266 New Codes – red bullets
- 129 Revised Codes – blue triangles
- 147 Deleted Codes – green text
- Many guideline changes – green text

CPT 2015 is effective January 1, 2015.

2015 Medicare
Physicians Fee Schedule
CONVERSION FACTOR CHANGES

- 2014 - $35.8228
- January 1 – March 31 - $35.8013
  - 0.06% change from 2014
- April 1 – December 31 - $28.2239
  - 21.2% change from 2014
  - 20.9% due to SGR
  - 0.06% due to budget neutrality adjustment

GLOBAL SURGERY-PROPOSAL

- Transforming all 10 and 90 - day globals into 0 - day globals
  - 10 - day in CY 2017
  - 90 - day in CY 2018
- Concerns with valuation
  - Appropriate # and level of E/M services
  - Valuation of E/M services included in 10 and 90 – day globals
  - Ability to keep up-to-date
  - Paying for visits that doctors don’t actually perform
- Follow up visits in the postoperative period will be billed separately and surgical package payments would be cut.
- Approximately 4500 codes will be revalued.

E & M UPDATE
OVERVIEW

- Military History added to Social History
- Inpatient Neonatal and Pediatric Critical Care guidance clarification
- Deletion of 99481 and 99482 – Total Body Systemic Hypothermia in Critically Ill Neonate
- Care Management Services guidance and instruction
- Chronic Care Management Services – new code 99490
- Complex Chronic Care Management Services guidance
- Complex Chronic Care Management Services – revised codes 99487 and 99489; deleted code 99488
- Advanced Care Planning – new codes 99497 and 99498

SOCIAL HISTORY

An age-appropriate review of past and current activities that includes significant information about:

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Military history
- Use of drugs, alcohol and tobacco
- Level of education
- Sexual history
- Other relevant social factors

MEDICINE SECTION: NEUROLOGY GUIDANCE

- **95887**: Needle electromyography, non-extremity muscle(s) done with nerve conduction, amplitude and latency/velocity study (add-on code)
- Report 95887 once per anatomic site (i.e., cervical paraspinal muscle(s), thoracic paraspinal muscle(s), lumbar paraspinal muscle(s), chest wall muscle(s), and abdominal wall muscle(s)). Use 95887 for a unilateral study of the cranial nerve innervated muscles (excluding extra-ocular and larynx); when performed bilaterally, 95887 may be reported twice.
- Use 95887 when a study of the cervical paraspinal muscle(s), or the lumbar paraspinal muscle(s) is performed with no corresponding limb study (95885 or 95886) on the same day.
- (For needle electromyography of anal or urethral sphincter, use 51785)
- (For non-needle electromyography of anal or urethral sphincter, use 51794)
- (For needle electromyography of larynx, use 95865)
- (For needle electromyography of hemidiaphragm, use 95866)
- (For needle electromyography of extra-ocular muscles, use 92205)
NEUROSTIMULATORS, ANALYSIS PROGRAMMING
REVISED CODE

▲ 99972  Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve), neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, up to 1 hour.

► More accurately describes the time requirement of “up to one hour” rather than “first hour.” Report for a minimum duration of 31 minutes. If less than 31 minutes, modifier 52 is required.

MEDICINE – CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS

▲ 96110  Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation per standardized instrument form.

► Revised to help differentiate from new code 96127. This revised code utilizes an instrument for testing, but focus is on developmental levels rather than emotional and behavioral conditions.

► 96127  Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder (ADHD) scale), with scoring and documentation per standardized instrument.

► One unit of service is reported for each instrument scored and documented.

► The related work of the physician’s interpretation of the scored instrument in the context of the patient’s history is a separately reportable evaluation and management (E/M) service. The E&M service can be either a complaint E&M or a preventive service.

ACTIVE WOUND CARE MANAGEMENT
ADDITION AND REVISION

► Codes 97607 and 97608 were established to report negative pressure wound therapy (eg, vacuum-assisted drainage collection) utilizing disposable, non-durable medical equipment (DME), including the provision of an exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care. Treatment of wounds either < or = 50 sq. cm vs > 50 sq. cm.

► Codes 97605 and 97606 were revised to include the phrase “utilizing durable medical equipment (DME)” to distinguish between these codes and new codes 97607 and 97608, which are intended to report non-durable medical equipment (DME). Treatment of wounds either < or = 50 sq. cm vs > 50 sq. cm.

► An exclusionary parenthetical note has been added to preclude the reporting of codes 97607 and 97608 with codes 97605 and 97606.
MEDICINE – ACTIVE WOUND CARE MANAGEMENT

▲ 97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

▲ 97606 total wound(s) surface area greater than 50 square centimeters.

▲ 97607 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

▲ 97608 total wound(s) surface area greater than 50 square centimeters.

NEW LANGUAGE – CPT SURGICAL PACKAGE DEFINITION

➢ By their very nature, the services to any patient are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services related to the surgery when furnished by the physician or other qualified healthcare professional who performs the surgery are included in addition to the operation per se:

➢ Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)

➢ Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia

➢ Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified healthcare professionals

➢ Writing orders

➢ Evaluating the patient in the postanesthesia recovery area

➢ Typical postoperative follow-up care

➢ Clarifies who can perform the service

➢ Identifies what services are included in addition to the operation

Musculoskeletal
Three revised codes for Arthrocentesis, aspiration and/or injection small, intermediate, major joint or bursa without ultrasound guidance

Three new codes for Arthrocentesis, aspiration and/or injection small, intermediate, major joint or bursa with ultrasound guidance, with permanent recording and reporting

One new code for Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) for radiofrequency

One new code for Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) for cryoblation

Deletion of closed treatment of rib fracture uncomplicated each (code 21800)

Three new codes for open treatment of rib fracture(s)

One new code for arthodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization) with image guidance

One revised code for arthodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed

One revised code for injection of contrast for knee arthrography

Newly added Musculoskeletal System cross-references

Newly added exclude cross-reference for Diagnostic Ultrasound for Needle Placement (Code 76942)

• 20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes) without ultrasound guidance

• 20604 with ultrasound guidance, with permanent recording and reporting

(Do not report 20600, 20604 in conjunction with 76942)

(If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

• 20605 (eg. tempomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) without ultrasound guidance

• 20606 with ultrasound guidance, with permanent recording and reporting

(Do not report 20605, 20606 in conjunction with 76942)

(If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)
CARDIOVASCULAR SYSTEM

**ARTHROCENTESIS – INTRODUCTION OR REMOVAL CONT’D**

- **20610** Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); **without ultrasound guidance**
  - 20611 with ultrasound guidance, with permanent recording and reporting
  - (Do not report 20610, 20611 in conjunction with 27370, 76942)
  - (If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

Summary of changes:
- New codes (20604, 20606, 20611) describe arthrocentesis with ultrasound guidance as an inclusive component.
- When ultrasound guidance is not used, existing arthrocentesis codes will be reported. Use existing codes for CT guidance, which can be reported separately.

**ARTHRITIS – INTRODUCTION OR REMOVAL CONT’D**

- **20604** Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); **without ultrasound guidance**
  - 20606 with ultrasound guidance
  - (Do not report 20604, 20606 in conjunction with 27370, 76942)
  - (If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

Summary of changes:
- New codes (20604, 20606, 20611) describe arthrocentesis with ultrasound guidance as an inclusive component.
- When ultrasound guidance is not used, existing arthrocentesis codes will be reported. Use existing codes for CT guidance, which can be reported separately.

**MUSCULOSKELETAL – OTHER PROCEDURES**

- **20982** Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed: radiofrequency
- **20983** cryoablation
  - (Do not report 20982, 20983 in conjunction with 76940, 77002, 77013, 77022)
  - Imaging inclusion and tumor margin clarification.
  - Moderate sedation is inherently part of the procedures.

**MUSCULOSKELETAL SYSTEM – FRACTURE AND/OR DISLOCATION**

Deletions:
- 21800 Closed treatment of rib fracture, uncomplicated, each
- 21810 Treatment of rib fracture requiring external fixation

New Parentheticals:
- (21800 has been deleted)
- (To report closed treatment of an uncomplicated rib fracture, use the Evaluation and Management codes)
- (21810 has been deleted. For external rib fixation, use 21899)
New Codes

• 21811  Open treatment of rib fracture(s) with internal fixation, includes thorascopic visualization when performed, unilateral; 1 – 3 ribs
• 21812  4 – 6 ribs
• 21813  7 or more ribs

For bilateral procedure, report CPT 21811, 21812 or 21813 with modifier 50.

> Previously reported with Category III codes (0245T – 0248T)

Changes

6 deleted codes

New parenthetical notes

New subsection titles & guidelines

6 new codes

New Codes

22510 – 22515 describe procedures for percutaneous vertebral augmentation, inclusive of imaging guidance.

> Vertebroplasty of the cervical, thoracic, lumbar, and sacral spine and vertebral augmentation of the thoracic and lumbar spine are included.

> Includes bone biopsy when performed, moderate sedation, and imaging guidance necessary to perform the procedure.

> Report one primary procedure code and an add-on code for additional levels.

> The sacrum and sacral procedures are reported only once per encounter.
**PERCUTANEOUS VERTEBROPLASTY AND VERTEBRAL AUGMENTATION**

**DELETED CODES**

Vertebroplasty procedures:
- 22520: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, thoracic.
- 22521: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, lumbar.
- +22522: each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Kyphoplasty procedures:
- 22523: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic.
- 22524: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar.
- +22525: each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

**WHY WERE THESE CODES DELETED?**

- The procedure codes (22520, 22521, 22522, 22523, 22524 and 22525) and the Radiological Supervision & Interpretation codes (72291 and 77292) were unbundled.
- Codes 22520, 22521, and 22522 include only thoracic and lumbar vertebroplasty, so cervical vertebroplasty remained an untitled procedure.
- Codes 22523, 22524, and 22525 include only thoracic and lumbar kyphoplasty, so cervical vertebral kyphoplasty remained an untitled procedure.
- Sacroplasty would become an untitled procedure after the Category III codes sunset in January 2015.
- The current kyphoplasty codes (22523-22525) do not include the moderate sedation inherent symbol.

**NEW CODES**

- 22510: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic.
- 22511: lumbar.
- +22512: each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure).
- 22513: Percutaneous vertebral augmentation including cavity creation (fracture reduction and bone biopsy included when performed), using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; thoracic.
- 22514: lumbar.
- +22515: each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).

See parentheticals after CPT 22512 and CPT 22515 which indicate that biopsies and treatment of fracture at the same level should not be reported.
Percutaneous vertebral augmentation procedures (22513-22515) are for the thoracic and lumbar area only. Percutaneous augmentation of the sacral region should be reported with Category III codes 0200T and 0201T, as appropriate.

▲ 0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed

▲ 0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

TOTAL DISC ARTHROPLASTY

▲ 22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical

➢ (Do not report 22856 in conjunction with 22554, 22845, 22851, 63075, 0375T, when performed at the same level)

➢ (Do not report 22856 in conjunction with 69990)

➢ (For additional interspace cervical total disc arthroplasty, see 22858, 0375T)

#• 22858 second level, cervical (List separately in addition to code for primary procedure)

➢ (Use 22858 in conjunction with 22856)

➢ (Do not report 22858 in conjunction with 0375T, when performed at the same level)

Category III code 0092T has been revised and renumbered to 0375T.

• 0375T Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels.

Summary of changes:

Use 22856 for first cervical level
Use add-on code 22858 for second level
Use Category III code alone for three or more levels
• **27279** Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.
  (For bilateral procedure, report 27279 with modifier 50)
  Replaces existing Category III code 0334T

• **27280** Arthrodesis, open, sacroiliac joint (including obtaining bone graft), including instrumentation, when performed.

  (To report bilateral procedure, report 27280 with modifier 50)

  (For percutaneous/minimally invasive arthrodesis of the sacroiliac joint without fracture and/or dislocation, use 27279)

▲ **27280** Arthrodesis, open, sacroiliac joint (including obtaining bone graft), including instrumentation, when performed.

  (To report bilateral procedure, report 27280 with modifier 50)

  (For percutaneous/minimally invasive arthrodesis of the sacroiliac joint without fracture and/or dislocation, use 27279)

▲ **61055** Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (eg, C1-C2)

  (Do not report 61055 in conjunction with 62302, 62303, 62304, 62305)

  (For radiological supervision and interpretation by a different physician or qualified health care professional, see Radiology)

Revisions:
- Removed redundant example in code description
- New parenthetical guidelines stating not to report this code with new codes for lumbar myelography
- Instructions for reporting radiological S&I have been revised to instruct separate reporting only if the S&I is performed by a different physician.
NERVOUS SYSTEMS REVISIONS

▲ 62284 Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)
  ➢ Do not report 62284 in conjunction with 62302, 62303, 62304, 62305, 72240, 72255, 72265, 72270.
  ➢ When both 62284 and 72240, 72255, 72265, 72270 are performed by the same physician or other qualified healthcare professional for myelography, see 62302, 62303, 62304, 62305.
  ➢ How specify that this is for reporting lumbar injections
  ➢ Parenthetical reference to the bundling of the injection with image guidance using new codes)

UPDATED GUIDELINE FOR INJECTION, DRAINAGE OR ASPIRATION OF SPINE AND SPINAL CORD

➢ Injection of contrast during fluoroscopic guidance and localization is an inclusive component of 62263, 62264, 62267, 62270, 62272, 62273, 62280, 62281, 62282, 62302, 62303, 62304, 62305, 62310-62319.
  ➢ Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes or the myelography via lumbar injection code.
  ➢ Image guidance and the injection of contrast are inclusive components and are required for the performance of myelography, as described by codes 62302, 62303, 62304, 62305.

NEW MYELOGRAPHY CODES

• 62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical
• 62303 thoracic
• 62304 lumbar/sacral
• 62305 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)

* See parentheticals throughout this section.
NEW BUNDLED MYELOGRAPHY CODES

- The surgical (lumbar puncture and contrast injection) and radiological supervision and interpretation (RS&I) components are now reported as a single code when both components are performed.
- Bundled codes were not created for myelography performed via cervical puncture.
- The existing surgical (puncture/injection) codes and RS&I codes remain active.
- Because these services may be performed separately
- If performed separately, report the code(s) describing what was performed.
- If both the surgical and RS&I portions of myelography are performed by the same provider, report the bundled code and NOT the separate component codes.

NEW TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK CODES - ABDOMINAL NERVE BLOCK

- 64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral by injection(s) (includes imaging guidance when performed)
- 64487 by continuous infusion(s) (includes imaging guidance when performed)
- 64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral by injection(s) (includes imaging guidance when performed)
- 64489 by continuous infusions (includes imaging guidance when performed)

TAP block is a peripheral nerve block used for post-operative pain control and abdominal analgesia.

Codes differentiate between unilateral and bilateral, and between injections vs. continuous infusions. All include image guidance.

NERVOUS SYSTEM DELETIONS

- 61334 Exploration of orbit; with removal of foreign body
- 61440 Craniotomy for section of tentorium cerebelli (separate procedure)
- 61470 Craniectomy, suboccipital; for medullary tractomy
- 61490 Craniotomy for lobotomy, including cingulotomy
- 61542 Craniotomy with elevation of bone flap; for total hemispherectomy
- 61609 Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)
NERVOUS SYSTEM DELETIONS

61875  Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical
62116  Reduction of craniomegalic skull; with simple cranioplasty
64752  Transection or avulsion of; vagus nerve (vagotomy), transthoracic
64761  pudendal nerve
64870  Anastomosis; facial-phrenic

ICD-10

ICD-10: ARE YOU READY?

Medicare states that the reasons to prepare for ICD-10 can be broken down into four categories:

- Clinical
- Operational
- Professional
- Financial
CLINICAL

- Informs better clinical decisions as better data is documented, collected, and evaluated
- Provides new insights into patients and clinical care due to greater specificity, laterality, and more detailed documentation of patient diseases
- Enables patient segmentation to improve care for higher acuity patients
- Improves design of protocols and clinical pathways for various health conditions
- Improves tracking of illnesses and severity over time
- Improves public health reporting and helps to track and evaluate the risk of adverse public health events
- Drives greater opportunity for research, clinical trials, and epidemiological studies

OPERATIONAL

Enhances the definition of patient conditions, providing improved matching of professional resources and care teams and increasing communications between providers
Affords more targeted capital investment to meet practice needs through better specificity of patient conditions
Supports practice transition to risk-sharing models with more precise data for patients and populations

PROFESSIONAL

Provides clear objective data for credentialing and privileges
Captures more specific and objective data to support professional Maintenance of Certification reporting across specialties
Improves specificity of measures for quality and efficiency reporting
Aids in the prevention and detection of healthcare fraud and abuse
Provides more specific data to support physician advocacy of health and public health policy
FINANCIAL

Allows better documentation of patient complexity and level of care, supporting reimbursement for care provided.

Provides objective data for peer comparison and utilization benchmarking.

May reduce audit risk exposure by encouraging the use of diagnosis codes with a greater degree of specificity as supported by the clinical documentation.

ICD-10 FOR NEUROSURGERY

Transition NOW!!

✓ Ensure Vendor Readiness
  - Check with your EMR vendor for upgrades and when the seamless installation of ICD-10 templates and new codes will be installed. Are there any “tools” to help Providers (prompts for laterality, anatomical site, etc.).
  - Conduct internal testing
  - Check with clearinghouses/billing services for readiness

✓ Perform an impact assessment
  - Look at budgets and scheduling for training
  - Run an ICD-9 frequency report for each surgeon and provider for at least the last 12 months.
  - Focus on the top 25-30 diagnosis codes
  - Run a CPT frequency report of the top 15-20 CPT procedures per provider
  - Compare the CPT and ICD-9 frequency reports for common areas for documentation this is an internal GAP analysis. Compare what was documented on the ICD-9 diagnoses, then decide what new or more specific documentation will be required for ICD-10

✓ Consider an outside Gap analysis to ensure proper coding and that you are following the latest ICD-10 Coding Clinic guidelines. The GAP analysis is a valuable tool for showing how provider documentation improvement will positively affect reimbursement.

  - ICD-10 is very specific to laterality, acute vs. chronic conditions, late effects, injuries.
  - Understand what new and/or additional documentation is required for proper coding, billing and reimbursement.
ICD-10 FOR NEUROSURGERY

- Determine Training Needs
  - Coders, Billing, Providers, Management, IT
    - Training needs will differ for each
- Determine Training Method(s)
  - On-site live training
  - Off-site training camps
  - Webinars
  - Distance learning
  - On-line training
  - Use of vendor
    - Choose a recognized Coding vendor for your Provider and coder training who can support all facets of Neurosurgery.

NEUROSURGERY FOR ICD-10

- Once ICD-10 training has been completed, adopt the new CMS 1500 billing form which allows up to 12 Diagnoses
- Perform external testing
  - When Medicare, Medicaid and the private carriers are ready to accept ICD-10 codes, submit parallel coded claims (ICD-9 and ICD-10)
- Continue to re-evaluate your documentation improvement and coding choices
  - Experts say that provider income and reimbursement will drop significantly, cash flow will trickle in slowly and the most common reason will be poor documentation and incorrect ICD-10 coding.
  - The carriers have already warned Providers that unspecified diagnosis codes will not be tolerated

ICD-9 VS. ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>724.02 Spinal stenosis, lumbar region, without neurogenic claudication</td>
<td>M46.06 Spinal stenosis, lumbar region</td>
</tr>
<tr>
<td></td>
<td>M48.07 Spinal stenosis, lumbosacral region</td>
</tr>
<tr>
<td></td>
<td>M99.23 Subluxation stenosis of neural canal of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.33 Obeseus stenosis of neural canal of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.43 Connective tissue stenosis of neural canal of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.53 Intervertebral disc stenosis of neural canal of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.63 Obeseus and subluxation stenosis of intervertebral foramina of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region</td>
</tr>
</tbody>
</table>
ICD-9 VS. ICD-10

ICD-9

724.3 Sciatica

ICD-10

M54.30 Sciatica, unspecified side
F45.41 psychogenic dorsalgia
G57.0 lesion of sciatic nerve
M51.1 sciatica due to intervertebral disc disorder
M54.41 lumbago with sciatica
M54.42 lumbago with sciatica, left side

ICD-9

354.0 Carpal Tunnel syndrome

ICD-10

G56.00 Carpal tunnel syndrome, unspecified upper limb
G56.01 Carpal tunnel syndrome, right upper limb
G56.02 Carpal tunnel syndrome, left upper limb

ICD-9

852.02 Subarachnoid hemorrhage following injury, without mention of open intracranial wound, brief loss of consciousness

ICD-10

S06.61A Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
S06.69A Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter
S06.99A Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial or subsequent encounter

Excludes 1: Head injury NOS (S09.90)
ICD-9 VS. ICD-10

ICD-9

742.0 Encephalocele

ICD-10

5 code choices depending on anatomic site
Range: Q01.0 – Q01.9
Examples:
Q01.0 Frontal encephalocele (Arnold-Chiari syndrome, type I)
encephalocele
encephalocystocele
encephalomyelocele
hydroencephalocele
hydrocephalocele, cranial
meningoencephalocele
Meckel-Gruber syndrome (Q61.9)
Q01.2 Occipital encephalocele (Arnold-Chiari syndrome, type II)
encephalocele
encephalocystocele
encephalomyelocele
hydroencephalocele
hydrocephalocele, cranial
meningoencephalocele
Meckel-Gruber syndrome (Q61.9)

ICD-9 VS. ICD-10

ICD-9

996.2 Mechanical complication of nervous system device, implant, and graft

ICD-10

17 potential codes based on specific documentation of the complication
Range: T85.01XA – T85.698A
Examples:
T85.01XA Breakdown (mechanical) of ventricular intracranial (communicating) shunt, initial encounter
T85.112A Breakdown (mechanical) of implanted electronic neurostimulator (electrode) of spinal cord, initial encounter
T85.190A Other mechanical complication of implanted electronic neurostimulator (electrode) of brain, initial encounter
T85.190A Other mechanical complication of implanted electronic neurostimulator (electrode) of brain, initial encounter

ICD-9 VS. ICD-10

ICD-9

722.4 Degeneration of cervical intervertebral disc

ICD-10

4 choices based on level of involvement
Code to the most superior level of disorder
M56.30 Other cervical disc degeneration, unspecified cervical region
M56.31 Other cervical disc degeneration, high cervical region
M56.32 Other cervical disc degeneration, mid cervical region
M56.33 Other cervical disc degeneration, cervicothoracic region

© 2015 THE CODING NETWORK, LLC
ICD-9 VS. ICD-10

ICD-9
737.30 Scoliosis, idiopathic

ICD-10

21 code choices based on level of involvement***

Range: M41.112 – M41.27

Examples:
- M41.112 Juvenile idiopathic scoliosis, cervicothoracic region (kyphoscoliosis)
- M41.113 Juvenile idiopathic scoliosis, thoracic region (kyphoscoliosis)
- M41.114 Juvenile idiopathic scoliosis, lumbar region (kyphoscoliosis)
- M41.115 Juvenile idiopathic scoliosis, thoracolumbar region (kyphoscoliosis)
- M41.116 Juvenile idiopathic scoliosis, thoracic region, congenital scoliosis due to bony malformation (Q76.3)
- M41.117 Juvenile idiopathic scoliosis, thoracic region, congenital scoliosis NOS (Q67.5)
- M41.118 Juvenile idiopathic scoliosis, thoracic region, kyphoscoliotic heart disease (I27.1)
- M41.119 Juvenile idiopathic scoliosis, thoracic region, postprocedural scoliosis (M96.8)
- M41.120 Juvenile idiopathic scoliosis, thoracic region, postural congenital scoliosis (Q67.5)

M41.121 Adolescent idiopathic scoliosis, cervicothoracic region (kyphoscoliosis)
- M41.122 Adolescent idiopathic scoliosis, thoracic region (kyphoscoliosis)
- M41.123 Adolescent idiopathic scoliosis, lumbar region (kyphoscoliosis)
- M41.124 Adolescent idiopathic scoliosis, thoracolumbar region (kyphoscoliosis)
- M41.125 Adolescent idiopathic scoliosis, thoracic region, congenital scoliosis due to bony malformation (Q76.3)
- M41.126 Adolescent idiopathic scoliosis, thoracic region, congenital scoliosis NOS (Q67.5)
- M41.127 Adolescent idiopathic scoliosis, thoracic region, kyphoscoliotic heart disease (I27.1)
- M41.128 Adolescent idiopathic scoliosis, thoracic region, postprocedural scoliosis (M96.8)
- M41.129 Adolescent idiopathic scoliosis, thoracic region, postural congenital scoliosis (Q67.5)

M41.13 Other idiopathic scoliosis, thoracolumbar region
- M41.14 Other idiopathic scoliosis, lumbar region
- M41.15 Other idiopathic scoliosis, thoracolumbar region, congenital scoliosis due to bony malformation (Q76.3)
- M41.16 Other idiopathic scoliosis, thoracolumbar region, congenital scoliosis NOS (Q67.5)
- M41.17 Other idiopathic scoliosis, thoracolumbar region, kyphoscoliotic heart disease (I27.1)
- M41.18 Other idiopathic scoliosis, thoracolumbar region, postprocedural scoliosis (M96.8)
- M41.19 Other idiopathic scoliosis, thoracolumbar region, postural congenital scoliosis (Q67.5)

Final words of wisdom:
Stay focused, don’t panic, follow all our recommendations, do your GAP analysis, get excellent training and learn the specifics of correct documentation.

Remember that insurance carriers may have different coding requirements

Your reimbursement is predicated on your successful preparation and implementation of ICD-10

REFERENCES
American Medical Association, CPT Changes, An Insider’s View, 2015
CMS ICD-10 Implementation Timeline, www.cms.gov/ICD10