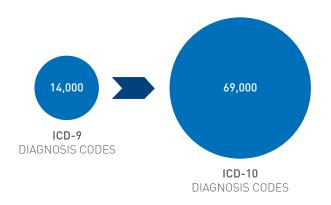
## **NUMBER OF CODES**



## CODE STRUCTURE

ICD-9-CM CODE FORMAT



CATEGORY

 $\otimes$ 

FTIOLOGY ANATOMIC SITE, **MANIFESTATION** 

3 TO 5 CHARACTERS FIRST DIGIT IS NUMERIC OR E OR V ALL OTHER DIGITS ARE NUMERIC

ICD-10-CM CODE FORMAT



**CATEGORY** 

 $\mathbf{x}$ 

FTIOLOGY ANATOMIC SITE, **MANIFESTATION**  **EXTENSION** 

1 TO 7 CHARACTERS FIRST DIGIT IS ALPHA ALL DIGITS EXCEPT SECOND ALPHA OR NUMERIC

#### ICD-10 **HISTORY**



# Common Radiology Diagnoses: ICD-9 to ICD-10 Mapping



## Radiology Diagnoses: ICD-9 to ICD-10 Mapping

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## Introduction

ICD-10 CM coding for radiology needs increased levels of specificity that should be included in physician documentation. This document provides an overview of the top diagnosis codes for radiology and the critical changes in ICD-10 that may impact coding and claim submission.

The table on the next page shows 3 categories of changes that impact documentation:

- 1) Diagnoses that require specificity that <u>must be included</u> before claims can be submitted for payment. If a coder receives documentation without the specificity, it must be returned to the provider for additional information. This category is highlighted in red.
- 2) Diagnoses that request specificity, but "unspecified" or "other" codes are available as a default. Because the intention of ICD-10 is to capture additional detail, it is unclear whether payers will accept "unspecified" codes or if they will be denied or delayed. Therefore, we encourage providers to include the detail in their documentation; the claim will only be returned to the provider in the event of a denial from the payer. This category is highlighted in yellow.

Conditions which generally provide a straightforward 1-to-1 transition from ICD-9 to ICD-10. No change to the documentation is required. This category is highlighted in green.

Following the table is an overview of top radiology codes and the documentation issues present with ICD-10.

Subsequent pages highlight the top diagnoses and the specific documentation requirements and issues for converting from ICD9 to ICD10.

ICD10 Change	Condition	Documentation Requirements				
<b>Critical</b> : Must be	Encounter/Episode of Care	Episode of care must be included for injuries, poisonings and other conditions. Designations include initial, subsequent, sequela. There is no "not otherwise specified" or "unspecified" option; the code must include the episode of care to be complete.				
Included in Documentation	Fracture Type	Additional details related to fracture type must be included, such as whether the fracture is open or closed, as well as details about the healing phase whether healing is routine or with complications such as delayed healing, nonunion or malunion. Open fractures should include the Gustillo open fracture classification. There is no "not otherwise specified" option.				
	Site Specificity	Greater level of specificity required, including:  * Specific area of limb (calf, ankle, etc)  * Specific quadrant of breast or area of chest wall Unspecified codes are available.				
	Laterality	Identify right/left/bilateral/unilateral limb, body location when available. Unspecified codes are available.				
Important:	Primary/Post Traumatic/ Secondary	Conditions such as osteoarthritis, urethritis, and other UTI diagnoses should include whether it is primary, secondary, or post-traumatic.				
Codes provide "Unspecified" option but lack of	Type of Tear	Type of tear needed. Examples for cartilage/meniscus (bucket-handle, peripheral, complex) or rotator cuff (incomplete/complete). "Unspecified" and "Other" codes are available.				
specificity may result in delayed	Patient History	Neoplasm screening should include applicable patient history resulting in need for service				
or denied payments by payor.	Artery and Chest wall specificity	With acute myocardial infarction, chest wall (anterior, inferior) an artery (circumflex coronary, descending coronary artery) should b included. The codes allow for "other sites" and "unspecified site."				
	Ulcer Stage	Pressure ulcers should be categorized based on stages from National Pressure Ulcer Advisory Panel (NPUAP) stages 1-4.				
	Identification of pregnancy term	Issues related to pregnancy should identify the trimester.				
	Disease Type	Type and origin of the disease should be included for diagnoses such as hypertension, COPD, and hyperlipedemia.				
	Acute V Chronic	Conditions such as respiratory or digestive orders should be designated as "acute" or "chronic"				
1-to-1 conversion from ICD9 to ICD10;	Normal or C-section birth/delivery	1-to-1 conversion; no additional documentation required				
no additional documentation required	Calculus of gallbladder or kidney	1-to-1 conversion; no additional documentation required				



## Most Common ICD-9 Radiology Codes and ICD-10 Documentation Issues

	177000 00111111	ICD-10 Documentation Issues							
ICD-9 Code	ICD-9 Description		Episode	-	Anatomical Site	Patient	Injury How /	Pregnancy	Othor
V76.12	Screening Mammogram	Laterality	of Care	Chronic	Specificity	History X	What	Trimester	Other  Routine Screening vs diagnostic (presenting w/symptoms); Inconclusive mammogram
786.50	Chest pain, unspecified				X Anterior, wall, central or musculoskeletal	X - Postoperative, neoplasm related, Post- thoracotomy			precordial, ischemic, pressure, discomfort, tightness, painful respiration
729.5	Pain unspecified limb	Х			X - Upper arm/forearm Thigh/lower leg Hands, fingers, foot, toes				
511.9	Unspecified Pleural effusion					Х			underlying condition: Influenza, tuberculosis, malignancy
793.19	Nonspecific abnormal finding of lung				X coin lesion, solitary pulmonary nodule	X			Identify neoplasm if applicable
784.0	Headache			X		x Post- traumatic; Allergies; medications			Description (cluster, tension, vascular) & duration & frequency
789.00	Abdominal pain, unspecified	Х			X - Upper/ lower quadrant Pelvic or perineal Epigastric Periumbilical				Tenderness, generalized, severe w/abdominal rigidity
786.05	Shortness of breath								In general, this is a 1-to-1 conversion.
611.72	Lump or mass in breast	Х				X			No longer distinguish breast mass v nodule
959.01	Head injury, unspecified		Х		Х	X	X		Loss of consciousness
V76.11	Screening Mammogram/high risk					X Family HX			
V58.81	Fitting/adjust of vascular catheter								This is a 1-to-1 conversion
611.89	Other specified disorders of breast	х				Х			No longer distinguish breast mass v nodule; specify symptoms or disorder (e.g. infection, lactation)
518.89	Other diseases of the lung			Х		Х			Chronic obstructive w/associated conditions; respiratory failure
719.45	Pain in joint, pelvic region & thigh	Х			Х				Specific code assigned to each joint
719.46	Pain in joint, lower leg	Х			X				Specific code assigned to each joint
	Cough					Х			Tobacco use; w/hemorrhage; bronchial
959.09	Injury of face and neck		Х		Х	X	X		Head v. face; superficial v. open wounds

## **Fractures**

ICD-10 coding for fractures has some of the most significant changes in the transition from ICD9 to ICD10. ICD-10 differentiates traumatic fractures from pathological fractures, and requires increased specificity in the documentation including:

- **Encounter/Episode of Care**: Documentation must include whether the visit is defined as initial, subsequent, or sequela.
- **Open/Closed Fracture**: Documentation must include a statement describing the fracture as open or closed.
- Classification: Depending on the fracture type, documentation may require the inclusion of the Gustillo classification of the fracture (such as for an open traumatic fracture of the long bone).
- **Fracture Pattern**: Documentation should include fracture details such as transverse, oblique, spiral, segmental, etc.
- **Alignment**: Documentation must note the alignment of the bones, specifically whether the fracture is displaced or Nondisplaced.
- **Site Specificity**: Documentation should include additional specificity regarding the name of bone and specific location of the fracture on the bone.
- Laterality: Documentation should include whether the fracture is on the right or left side of the body.
- **Healing**: Documentation is required to identify whether healing is routine, delayed, malunion or nonunion for each encounter.

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Here is an example of the increased level of specificity needed in the documentation for ICD-10:

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Fracture of Unspecified Part of Clavicle	810	S42	Fracture of Unspecified Part of Clavicle
Initial Encounter		0	Initial Encounter
Fracture of clavicle, closed, unspecified part	810.00	S42.001A	Unspec. part – right clavicle - closed
		S42.002A	Unspec. part – left clavicle – closed
		S42.009A	Unspec. part - unspec. clavicle - closed
Fracture of clavicle, open, unspecified part	810.10	S45.001B	Unspec. part – right clavicle – open
		S42.002B	Unspec. part – left clavicle – open
		S42.009B	Unspec. part – unspec. clavicle - open
Fracture of Sternal End of Clavicle			Fracture of Sternal End of Clavicle
Fracture of clavicle, closed, sternal end of clavicle	810.01	S42.011A	Anterior displaced fracture - Sternal end Right clavicle - closed
		S42.012A	Left clavicle – closed
		S42.013A	Unspec. clavicle – closed
	810.01	S42.014A	Posterior displaced fracture - Sternal end Right clavicle - closed
		S42.015A	Left clavicle – closed
		S42.016A	Unspec. clavicle – closed
		S42.017A	Nondisplaced fracture - Sternal end Right clavicle - closed
		S42.018A	Left clavicle – closed
		S42.019A	Unspec. clavicle – closed
Fracture of clavicle, open, sternal end of clavicle	810.11	S42.011B	Anterior displaced fracture – Sternal end Right clavicle - open
		S42.012B	Left clavicle – open
		S42.013B	Unspec. clavicle – open
		S42.014B	Posterior displaced fracture  Sternal end  Right clavicle - open
		S42.015B	Left clavicle – open
		S42.016B	Unspec. clavicle – open
		S42.017B	Nondisplaced fracture – Right clavicle - open
		S42.018B	Left clavicle – open
		S42.019B	Unspec. clavicle – open

## **Injuries**

Along with Fractures mentioned above, ICD-10 coding for conditions resulting from injuries represents a significant change. Greater specificity is needed to identify the specific part of the body that sustained the injury. Also, ICD-10 requires that that injury codes include the episode of care / encounter, using the following:

- Initial encounter
- Subsequent encounter
- Sequela

Extensions for initial encounters can be used if the patient is receiving active treatment for the injury (such as evaluation/treatment by a new physician, or surgical treatment). Extensions for subsequent encounters are used after the patient has received active treatment and is now receiving routine care during the healing or recovery phase (such as medication adjustment, follow up visits, cast change, etc). Sequela is used for complications or conditions that arise as a direct result of an injury, such as scars that occur after a burn (the scars, then, are sequela of the burn).

Also, whenever possible, the cause of the injury should be included in the documentation, with as much detail as possible (where, when, how).



## **Common Diagnoses for CT Scans**

Common or Top Diagnoses for CT Scans can be categorized below:

**Diagnosis** – **Headache:** ICD 10 provides for additional specificity regarding whether the headache condition is intractable or not intractable. Here is a brief excerpt:

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Cluster Headaches and Other	339.0	G44.0	Category: Other Headache Syndromes
Cluster headache, unspecified	339.00	G44.001	Intractable
		G44.009	Not intractable
Episodic	339.01	G44.011	Episodic cluster headache, Intractable
		G44.019	Episodic cluster headache, Not intractable
Chronic	339.02	G44.021	Chronic cluster headache, Intractable
		G44.029	Chronic cluster headache, Not intractable

#### **Injury Diagnoses – Head & Abdomen**

As mentioned above in the "Injury" section, coding for injuries must include the episode of care.

## **Common Diagnoses for MRIs**

Some of the most common diagnoses for MRIs come from the spine area. In ICD-10, greater specificity to identify the spinal region is required. Here is an example and excerpt of popular spine diagnoses and the ICD-10 conversions.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Cervical Spondylosis w/o myelopathy	721.0		
		M47.811	Other Spondylosis without radiculopathy – occipito-atlanto-axial region
		M47.812	-cervical region
		M47.813	-cervicothoracic region
Displacement of cervical intervertebral disc	722.0		
		M50.20	Other cervical disc displacement – unspecified cervical region
		M50.21	-occipito-atlanto-axial region
		M50.22	-mid-cervical region
		M50.23	-cervicothoracic region
Degeneration of lumbar or lumbosacral intervertebral disc	722.52		
		M51.36	Other intervertebral disc degeneration, lumbar region
		M51.37	Other intervertebral disc degeneration, lumbosacral region

## **Specificity in Diagnosing Neoplasms**

We have all heard that ICD-10-CM codes are more specific than those in ICD-9-CM and there are many more of them. But ICD-10 doesn't just offer more codes to describe a patient's condition; it also establishes the medical necessity of a service and describes the intensity and volume of the service better than ICD-9.

Below we highlight what this means for cancer reports prepared by radiologists.

Cancer diagnoses, whether they are of the lung, breast, colon, uterus, bladder, or brain are an area where there is often a lack of specificity in current radiology documentation. We know that one of the reasons radiologists are at a disadvantage for documenting specificity of cancer diagnoses is because they must depend on the referring physician to give the reason behind the order and other pertinent information related to a study.

However, aside from referring physician issues which must be addressed by radiologists and imaging centers, for ICD-10, radiologists must be more specific and detailed in their documentation and wording of a completed exam. ICD-10 requires documenting the type of neoplasm, where it is located, and whether it is on the right or left side of the body. Radiologists must include the following when dictating their radiology reports for patients with cancer.

#### Type of neoplasm

The medical record must include documentation as to whether the neoplasm is:

- Benign
- Malignant Primary or secondary
- Ca In situ
- Uncertain behavior
- Unspecified behavior

#### **Laterality**

"Laterality" (side of the body affected) is a new coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for certain neoplasms will require documentation of the side/region of the body where the condition occurs. Although, unspecified side is allowed in ICD-10 coding, it is to be used as a last resort.

- Right side
- Left side
- Bilateral
- Unspecified side/region

#### **Location of the Neoplasm**

Some examples of location specificity:

- Esophagus Upper, middle, or lower third
- Pancreas Head, body, or tail of pancreas
- Bronchus and Lung right or left bronchus/lung, upper or lower lobe, overlapping sites



The following chart is an example of the specificity of coding needed for diagnosing *neoplasm of the breast*. Complete ICD-10 coding requires that radiologists document: the type of neoplasm, which breast, which quadrant of the breast, and whether the patient is female or male.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Malignant Neoplasm of Breast		C50	Category: Malignant Neoplasm of Breast
		C50.011	Malignant neoplasm of nipple and areola, right female breast
		C50.012	Malignant neoplasm of nipple and areola, left female breast
		C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
		C50.021	Malignant neoplasm of nipple and areola, right male breast
		C50.022	Malignant neoplasm of nipple and areola, left male breast
		C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
		C50.2	Malignant neoplasm of upper-inner quadrant of breast
		C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
		C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
		C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
		C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
		C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
		C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast



# **Hematuria and Cystitis**

The diagnoses of hematuria and cystitis are common to renal/retroperitoneal ultrasounds.

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Hematuria	599.7	R31	Hematuria
Hematuria, unspecified	599.70	R31.9	
Gross Hematuria	599.71	R31.0	
Microscopic hematuria	599.72	R31.1	Benign essential microscopic hematuria
		R31.2	Other microscopic hematuria
Cystitis	595	N30	Cystitis
Acute cystitis	595.0	N30.00	w/out hematuria
	1	N30.01	w/hematuria
Chronic interstitial cystitis	595.1	N30.10	Chronic cystitis w/out hematuria
		N30.11	Chronic cystitis w/hematuria
Other chronic cystitis	595.2	N30.20	w/out hematuria
		N30.21	w/hematuria
Trigonitis	595.3	N30.30	w/out hematuria
		N30.31	w/hematuria
Cystitis in diseases classified elsewhere	595.4	N30.80	Other cystitis w/out hematuria
Mark and the Miles		N30.81	Other cystitis w/hematuria
Cystitis, Unspecified	595.9	N30.90	Cystitis, unspec. w/out hematuria
100		N30.91	Cystitis, unspec. w/ hematuria
Other Specified types of cystitis			0.00 (
Cystitis cystica	595.81	N30.80	Other cystitis w/out hematuria
		N30.81	Other cystitis w/hematuria
Irradiation cystitis	595.82	N30.40	w/out hematuria
		N30.41	w/hematuria
Other	595.89	N30.80	w/out hematuria
		N30.81	w/hematuria