ORTHOTICS AND PROSTHETICS and ICD-10

The orthotic and prosthetic profession has a unique role within healthcare. There are few specialties where care is ordered by one entity, referred to another for comprehensive management and follow-up, and then paid for by another entity. All of the interactions and relationships along the continuum of care are very important, and the goal of all parties is to achieve the best outcome for the patient. However, although the policy/payer demands are on physician documentation, the financial consequences fall on the O&P practitioner when these demands are not met.

Such is the specter of the looming change to International Classification of Diseases-10 (ICD-10) effective October 1, 2015. The World Health Organization developed this code set, which communicates specific conditions of human health, to reflect advances in medicine and medical terminology. This change has been a long time coming; the ICD-9 classifications have been in use for more than 30 years. The implementation of ICD-10 has been delayed repeatedly; however, CMS has stated that it will not accept any claims that include ICD-9 codes or both ICD-9 and ICD-10 codes for dates of service on or after October 1.

Large institutions and major physician groups have provided training in preparation for the change. There is a continuing concern, however, as to the readiness of small groups, particularly rural practices, such as those who may currently refer to O&P professionals with a diagnosis of “amputation” or “plantar fasciitis.” Although the largest responsibility for correct coding lies with the prescribing physician, familiarity with ICD-10 codes and ability to recognize errors may help orthotists and prosthetists more smoothly make this transition. WHO has publicized the transition to ICD-10 in order to prepare healthcare professionals, but for many this adjustment will be a difficult one. You can still take action to prepare over the next two weeks.

OVERVIEW OF ICD-10 CODES

The ICD-10 code format is expanded, which means that each code can include greater detail. Left or right (laterality), severity of the condition, cause of the injury, and complications may all be included within the code. There are about 68,000 diagnostic codes under the new ICD-10-CM (clinical modification) codes—five times more than under ICD-9-CM.

ICD-10 codes use between three and seven digits.

- The first digit is always a letter, which may be any letter except “U.”
- The second digit is always a number.
- The remaining characters may be letters or numbers.
- A decimal point is placed after the third digit.
• When laterality is specified, “1” is used for right and “2” is used for left. For example, M24.571 is the code for “Contracture, right ankle.”

• A seventh character may be necessary to define the stage of treatment. The letter “X” is used as a placeholder for other positions to ensure stage of treatment remains the seventh character in codes shorter than six characters.
  o “A” is used to designate initial treatment; the first time an injury/condition is treated.
  o “D” is used for subsequent routine treatment of that condition, such as follow up appointments.
  o “S” is used to designate sequela, or conditions/complications that arose as a result of the initial diagnosis, e.g., chronic pain resulting from an injury.

EXAMPLE
Consider the following example of coding for treatment of a fracture: If a fracture brace is used as the initial treatment of a fracture, the diagnosis code would include an “A” in the seventh position to indicate “initial treatment.”

If a cast is used as the initial treatment for the fracture, and then a brace is prescribed for continued stabilization, the diagnosis code would include the seventh character “D” indicating “subsequent routine treatment” of the fracture.

If the patient now has a joint contracture as a result of the fracture, the diagnosis code would include the seventh character “S,” indicating “sequela,” or condition caused by the original injury. The code detailing the resulting condition (the contracture) should also be included.

One important exception to this is for deficits resulting from a CVA. These have their own codes that include both the specifics of the CVA and the resulting condition. For example, I69.351 is for “Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.”

HELPFUL TOOLS
There are calculators to help you find the correct ICD-10 code based on the ICD-9 code, like this one for AOPA members: http://www.aopanet.org/coding-reimbursement/icd-10-bridge/ or this one from the American Academy of Professional Coders: https://www.aapc.com/icd-10/codes/

These tools are helpful for getting in the ballpark for the correct ICD-10 code. However, with the specificity of ICD-10, often a single ICD-9 code will correspond to many ICD-10 codes, and using the “unspecified” code is unlikely to be acceptable. In addition, there are also ICD-9 codes not represented in ICD-10; for example, posterior tibial tendon dysfunction is not listed in ICD-10.
The ICD-10 code changes will affect all Health Insurance Portability and Accountability Act-covered entities—hundreds of thousands of providers, payers, and claims handlers. The codes will be used to authorize and calculate trillions of dollars in payments from Medicare, Medicaid, commercial insurers, Tricare, and the Veterans Health Administration to hospitals, physicians, and other providers. With this large change looming over the healthcare system, understanding and preparedness are paramount.