

ICD-10 Radiology Guidance: SPINE

ICD-10 ESSENTIALS for SPINE

The following elements are essential for the proper ICD-10-CM coding of conditions found in the **Spine**:

OSTEOPOROSIS

- Type
- Underlying Cause
- Pathological Fracture Status
- Long Term Drug Therapy Status

INTERVERTEBRAL DISC DISEASE

- Type of Condition
 - Location
 - Myelopathy Status
 - Radiculopathy Status

Common Spine Related Diagnoses	ICD-10 Specificity Guidance
Low Back Pain	Distinguish if with Sciatica
Osteopenia	Specify Anatomical Location
	Specify Laterality
Spondylosis	Identify Specific Region affected
	Spondylitis vs. Spondylopathy
	vs. Spondylolisthesis
	 Distinguish if with Myelopathy
	 Distinguish if with Radiculopathy

Osteoporosis

Because osteoporosis is a systemic condition affecting all bones of the musculoskeletal system, the code is not location specific unless a pathologic fracture is present. Osteoporosis is included in the guidance for spinal conditions as it is a primary area that is evaluated and treated for this condition. There are several areas of documentation that are needed to completely report osteoporosis.

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The type and underlying cause of the osteoporosis should be documented. <u>Osteoporosis will be</u> <u>submitted as age-related if no further information is provided as it is the default option within ICD-10</u>.

Туре	Cause	
Age-related	Drug-Induced	
Involutional	Idiopathic	
Postmenopausal	Disuse	
Senile	Post Oophorectomy	
Localized	Post-Traumatic	

Long-Term Drug Therapy

- For many patients who have been diagnosed with osteoporosis, a drug therapy treatment plan (i.e., bisphosphonates) may be in place. ICD-10 allows for the additional reporting of this information and could be a consideration for payment with certain procedures.
- Patients who receive long-term steroid therapy are considered at a greater risk of osteoporosis. This information can also be a consideration for payment with certain procedures and is recommended to be documented when known.

Osteoporosis - is categorized as either with or without current pathological fracture.

- ICD-10 guidelines state that a fracture should be reported as *pathological* if a patient with known osteoporosis suffers a fracture from a minor fall that would not usually break a healthy bone.
- If the patient had a pathological fracture in the past but it is now healed, the condition would be submitted as *without current pathological fracture*. If this past history is known, it should be documented to allow for complete reporting of the condition.
- If a pathological fracture is present, additional elements are needed.
 - Location of the Fracture
 - Episode of Care
 - Initial Encounter
 - Patient is undergoing active treatment for the condition
 - Subsequent Encounter
 - After active treatment and the patient is receiving routine care during the healing phase
 - Sequela
 - Complications or conditions that arise as a direct result of a condition
 - There is not a "default" or "unspecified" option for episode of care.



 The coder will use the provided documentation to make a reasonable determination of the episode of care. If that determination can't be made from the documentation, the report will be returned for additional information.

Unspecified Example:	Specified Example:
Indication: Osteoporosis	Indication: pathological fracture T11 with senile osteoporosis
Coded as: age-related osteoporosis without current pathological fracture	Coded as: age-related osteoporosis with current pathological fracture, vertebrae

Intervertebral Disc Disease

ICD-10 allows for more detailed reporting of these conditions by providing options specific to the type of disc disease, general region of the spine affected, and identification of associated myelopathy and radiculopathy.

Type of Condition	Location	Manifestations		
Displacement	Cervical	With Myelopathy		
Degeneration	High-cervical	With Radiculopathy		
Other (specify)	Mid-cervical			
	Cervicothoracic			
	Cervical level			
	Thoracic	Thoracic		
	Thoracolumbar			
	Lumbar			
	Lumbosacral			
Sacrococcygeal				

Specified Example:

Indication: **cervical disc disease** Coded as: *cervical disc disorder*, <u>unspecified</u>, <u>unspecified</u> cervical region Indication: **HNP, C6-C7, with radiculopathy** Coded as: *cervical disc disorder, with radiculopathy, mid-cervical region*



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Sources:

- *ICD-10-CM Draft Official Guidelines for Coding and Reporting 2014*; Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), 2013.
- Best Practices for ICD-10-CM Documentation and Compliance, AMA 2012.
- *CSI Navigator for Radiology Diagnosis Coding with ICD-10-CM, 2013 Edition,* Coding Strategies, Inc. 2012.