# Medicare Diagnosis

## ICD-10 Update

- CMS has officially set the deadline for implementation of the ICD-10 code set for October 1, 2015.
- CMS has also launched a new ICD-10 resource, www.roadto10.org.
- The best ICD-10 resource for chiropractic is ChiroCode.

## Diagnosis

- The diagnosis is one of two codes that you place on the CMS 1500 form when you submit a claim.
- The diagnosis communicates the patient's condition to the computer that reads the claim.
- The computer is programmed to read the diagnosis and make certain decisions, including whether or not you get paid.
- The more accurately that you diagnose the patient, the better you can manage the case
- The better you will get paid
- The less likely you are to be reviewed
- "The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named."
- Spinal Regions:

| Area of Spine | Names of Vertebra | Number of Vertebra | Short Form or Other Name |
|---|---|---|---|
| Neck | Occiput | | Occ, CO |
| | Cervical | 7 | C1 thru C7 |
| | Atlas | | C1 |
| | Axis | | C2 |
| Back | Dorsal or Thoracic | 12 | D1 thru D12 |
| | | | T1 thru T12 |
| | Costovertebral or Costotransverse | | R1 thru R12 |
| Low Back | Lumbar | 5 | L1 thru L5 |
| Pelvis | ILII, R and L | | I, SI |
| Sacral | Sacrum, Coccyx | | S, SC |

_____

_____

_____

_____

_____

## Which Diagnosis Code to Use

- There are currently two groups of codes that are used by chiropractors to identify the subluxation:
- The ICD-9 code 739.x
- The ICD-9 code 839.x
- ICD-9 code 839.X
- Defined as "other, multiple, and ill defined dislocations."
- The 830-839 series of diagnoses are for dislocations and subluxations.
- The subluxations referenced here are medical subluxations.
- Taber's Cylopedic Medical Dictionary defines subluxation as: A partial or incomplete dislocation.
- This section provides individual codes for open dislocations and closed dislocations.
- Open dislocations include:
    - Compound,
    - Infected, or
    - With foreign body
- Closed dislocations include:
    - Complete,
    - Dislocation NOS,
    - Partial,
    - Simple, or
    - Uncomplicated
- Clearly, the 839.X series of codes is not for use by chiropractors.
- The 739.X series of codes.
- These are defined as: Nonallopathic lesions not elsewhere classified.
- They include:
    - Segmental Dysfunction
    - Somatic Dysfunction
- This is the code that was designed for use by chiropractors.
- This is the code that we should use for diagnosis of the subluxation.
- This code is listed in every state's Local Coverage Determination and thus is required by every carrier or MAC.

## Diagnosis

- Diagnosis is part of the assessment portion of our documentation.
- The history (or subjective portion) of your documentation drives your examination (or objective portion).
- The history and examination together drive your diagnosis.
- In the History the patient will tell you what region is bothering them.
- You follow up on this information in the consultation and dig for any additional problems.
- The History and consultation combined will give you a good picture of the problem.
- You will use this information to determine which tests to perform during the examination.
- The results of the History, consultation, and Examination combined will give you a solid picture of the problem and what, if any additional tests may be indicated.
- All of this information combines to lead you to your diagnosis.

_____

_____

_____

_____

_____

- You should choose a diagnosis that is a specific as possible.

**Areas of the Spine**

| Area of the Spine | Name of Vertebra | ICD-9 Code |
|---|---|---|
| Neck | Occiput | 739.0 |
| | Cervical | 739.1 |
| Back | Thoracic | 739.2 |
| Low Back | Lumbar | 739.3 |
| Pelvis | ILLII R & L | 739.5 |
| Sacral | Sacrum, Coccyx | 739.4 |

**Local Coverage Determination**

- The Local Coverage Determination (or LCD) contains the policies for the MAC regarding a specialty (in this case chiropractic)
- The following is taken from the LCD for Illinois. There is similar language in almost every other LCD.
- The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.
- Local Coverage Determinations are issued by Medicare Administrative Contractors to clarify policy regarding specific services.
- All but four states and Railroad Medicare have LCDs specific for chiropractic.
- North Carolina, South Carolina, Virginia, and West Virginia do not have LCDs specific for chiropractic.
- At the top of each LCD is a section marked “Document Information”.
- In that section will be a “Revision Effective Date”.
- This date will tell you how current the information is that is in this document.
- You should have a copy of your state’s LCD for reference.
- You can find the chiropractic LCD on the Mac’s website.
- Or you can find them in the “resources” section of my website.

_____

_____

_____

_____

_____

- Most LCDs contain the information provided in the Medicare Benefits Policy Manual, Chapter 15, section 240 that is specific to the documentation requirements for chiropractors.
- Some will also contain utilization guidelines for chiropractic.
- The following is an example from the WPS LCD:
- Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program.
- Other information, such as this on documentation requirements, will be present:
- Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without ICD-9 codes will be denied as being not medically necessary. Documentation in the form of progress notes need not be submitted with each claim but be available upon request.
- Remember that these are samples from the WPS LCD.
- Yours may be different.
- This is why you should have a printed copy on hand for your office.
- Most LCDs contain a list of diagnoses that are to be used for secondary diagnoses.
- These are the only diagnoses to be used for this MAC.
- The list below is from the WPS LCD.
- Some LCDs break them into sections like this and some do not.
- SAMPLE OMITTED TO KEEP NOTES SHORT. FIND THE CHIROPRACTIC LCD AT YOUR MAC'S WEBSITE.

## Hierarchy of Diagnosis

- Neurological Diagnosis
    - 724.3 Sciatica
- Structural Descriptor Diagnosis
    - 722.52 Degeneration of Lumbosacral Intervertebral Disc
- Functional Diagnosis
    - 719.7 Difficulty Walking
- Soft Tissue, Extremity, Complicating Factors
    - 847.0 Sprains and Strains of the Neck
- The condition must be coded to the highest level of specificity.
- If the highest level of specificity is "soft tissue" then that is what you code.

## Diagnosis

- The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.
- In other words, the area(s) of chief complaint must be consistent with the area(s) of examination.
- Which must be consistent with the area(s) of adjustment.
- Which must be consistent with the area(s) billed.
- The diagnosis must reflect this.

_____

_____

_____

_____

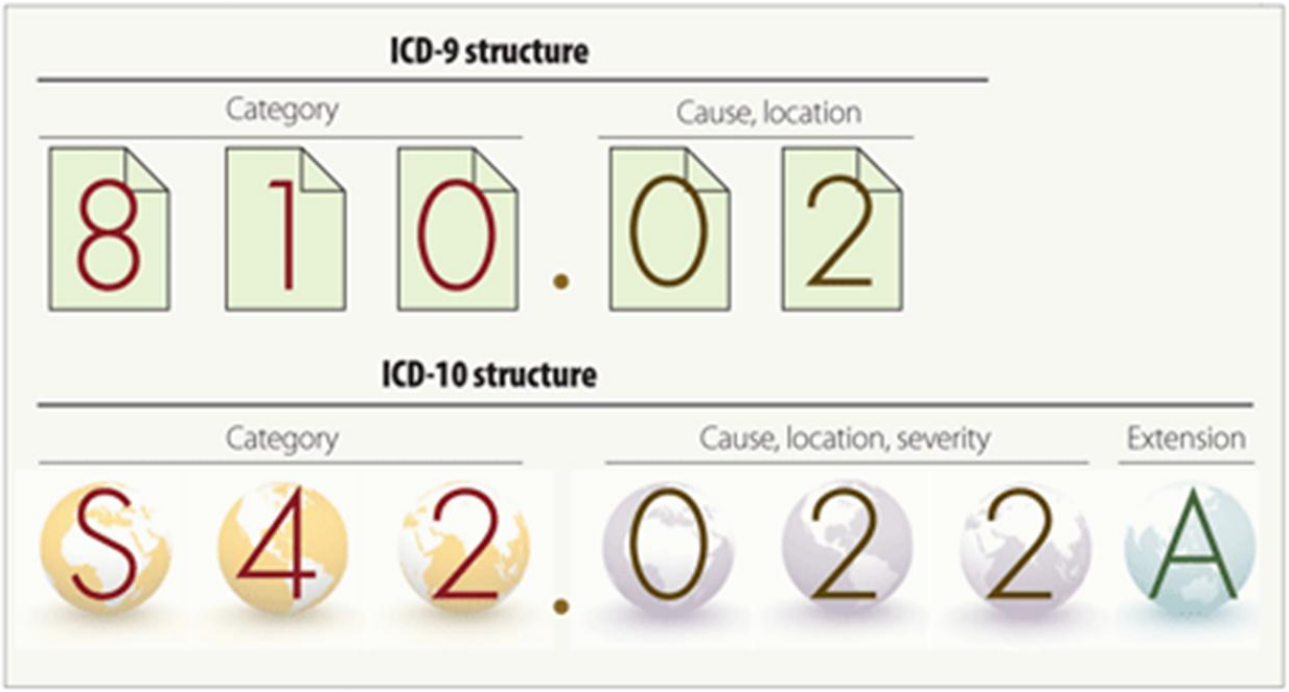
_____

- The diagnosis must be consistent with the orthopedic and neurological test findings.
- For example: If you have a diagnosis of Sciatica then you should have a compliant of low back pain with radiation down the leg and positive Laseque's and Braggard's tests.
- You must have imaging reports to confirm certain diagnoses.
- For example: If you have a diagnosis of Degenerative Disk Disease you should have an x-ray report on file that lists disk thinning and spurring on the vertebral margins.
- Your diagnosis can be changed as new information becomes available.
- For example: A patient has both low back and cervical diagnoses. At the first re-exam the cervical problem has resolved. It is appropriate to remove the cervical diagnosis from the claim form for services after the re-exam.
- The diagnosis is part of the Assessment portion of the SOAP notes.
- It is your opinion of what is wrong with the patient.
- The better that you communicate this information to third party payers, the better you will be paid.

## ICD-10

- The implementation deadline for ICD-10 is now October 1, 2015.
- The ICD-10 coding system is completely different from the ICD-9 system.
- The ICD-9 code set has number combinations up to 5 places.
- The ICD-10 codes consist of letter and number combinations up to 7 places.
- There are about 17,000 ICD-9 diagnosis codes.
- There are about 70,000 ICD-10 diagnosis codes.

**Gross anatomy of ICD-9 and ICD-10 codes**




**Source:** American Health Information Management Association

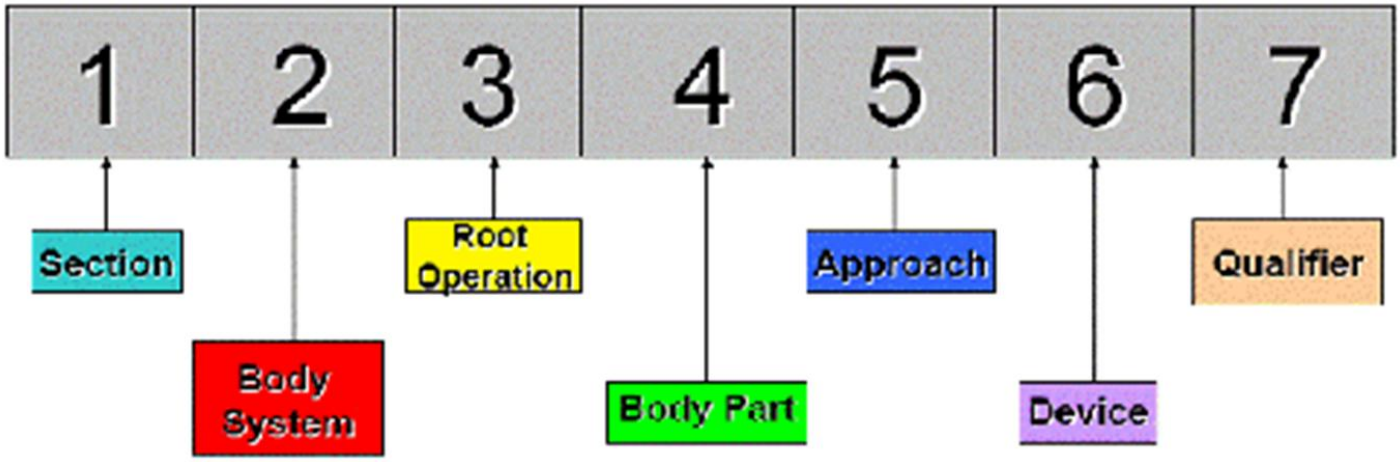
_____

_____

_____

_____

_____




- Some Medicare Administrative Contractors have Draft LCDs that include ICD-10 codes.
- Some of these LCDs include extremity diagnoses.
- Some MACs have the codes divided like they do now and some do not.
- One MAC has 108 pages of ICD-10 codes as opposed to 9 pages of ICD-9 codes.
- There is still a lot to be sorted out regarding which ICD-10 codes will be allowed for Medicare and which will not.
- As we get closer, we will better know what Medicare and the MACs want from us.

## Summary

- Medicare is very clear that the doctor is responsible for communicating the patient's condition to them.
- Understanding the diagnosis process and choosing the most accurate and specific diagnoses for that patient will convey the most accurate information to Medicare.
- Medicare is legally obligated to pay for care that is medically necessary.
- Clear and accurate diagnoses are an important part of proving medical necessity.

_____

_____

_____

_____

_____