ICD-10: The A&D 7th Character

Here's some insight on this most confusing character.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

I'm sure none of you remember the last CodinglinePARTICULARS article I wrote, the one where I noted that CMS had unilaterally decided to eliminate the bundled payment for surgical services that span a 10 and 90-day period. In other words, eliminate the 10 and 90-day global period now used to value and define surgical codes. Despite comments from most medical specialty associations, and I'm paraphrasing here, on the order of "you've got to be kidding me"—only with a bunch of 4-letter words thrown diplomatically in—CMS was going to do what it wanted to do.

Well, not so fast, CMS. BAM. Another Act of Congress…tucked at the end of the House bill was the following language:

"Payment for global surgical packages

(A) Prohibition of implementation of rule regarding global surgical packages

(i) In general

The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods."

Oh, happy days. So, you can forget that portion of the article last month that went on about CMS and about there being no "Care" in Medicare.

ICD-10: The A&D 7th Character

Of all the ICD-10 characters, it's the 7th character that providers and coders complain is the most confusing. Is it any wonder? No other country using ICD-10 has a seven-character code set, probably for good reason. Canada, in a moment of superiority (2001, you might wish to mark that done in your diaries; it quickly passed, no harm reported), decided to include a 6th character in its ICD-10-CA version. To be fair, Canada edged out Senegal, Togo, and the Vatican by including both diagnostic and procedural codes to top out at 17,000 or so codes.

Is anyone surprised that the United States, patiently waiting to avenge Canada's role in the War of 1812, purposely held back introducing ICD-10 until it could triumphantly declare itself ICD-10 champion, bringing in the double gold for the "Most ICD-10 Characters Ever (No Really, Ever)" and "Most ICD-10 Codes in the Galactic Quadrant". On October 1, 2015, the United States (as predicted by Harry Goldsmith, DPM) will implement "ICD-10-CM" (Clinical Modification—the unique, some say "exceptional" United States ICD-10 version of diagnosis, conditional, circumstance, signs and symptom codes). Twenty-one years in the making: 68,000 + codes (but no unique bunion or paronychia codes, that would be showing off); up to 7th characters—take that Canada.

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What Is So Special About the 7th Character?

The 7th character goes beyond defining the diagnosis. The 7th character, at least with injury codes and a few musculoskeletal codes, provides information regarding whether the provider submitting the claim is actively treating the patient or following up; or whether the presenting problem is the result of a previous injury; or whether the patient is doing just fine in his/her fracture healing or having significant problems. Why, you might ask, is this important to be

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included on a claim form since the information is readily available in the medical record (and possibly even hinted at in the listed CPT code)? The answer is, it is easier for government agencies, payers, and researchers to data mine off a claim form than review medical records. The carrot—justification for the providers given is that if the data can be gleaned magically from the claim form, auditors will be knocking on your door less often. Of course, if you believe that….

When experts talk about glitches that could occur in processing claims—software issues, not matching your billed ICD-10 codes to those on the payer's accepted policy code list, and/or confusion on either the payer or the provider side regarding which 7th character code is the most correct given the circumstances—they talk about laterality (typically in the 6th character code position) and the 7th character. Glitches include, by the way, loss of productivity in your practice, inefficiencies in office workflow, more staff diverted to code look-ups, and, oh yes, having the claim rejected because of coding or software problems.

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So, what are examples of 7th character use? What do the guidelines say about choosing the right code? NOTE: This article will focus only on those circumstances when "A" (initial encounter) and "D" (subsequent encounter) are options. Future articles will go into 7th character "S" (sequela), "1", "2", "B", "C", "E", "F", "G", "H", "J", "K", "M", "N", "P", "Q", and "R" use.

"A" Is for "Initial Encounter"; "D" Is for "Subsequent Encounter"—Maybe

Actually, "A" is not necessarily for initial encounter. I know what you're thinking: "initial encounter" is a term you are well familiar with. Providers and coders alike depend on initial encounter coding every day… as an E/M CPT service code. We know initial encounter means "office or other outpatient visit for the evaluation and management of a new patient." What we didn't know is that the people at the National Center for Health Statistics (NCHS), the Federal agency responsible for the development and use of ICD-10 in the United States, would borrow the term for their own use. Consequently, "initial encounter" may not mean what you think it obviously should mean. By the way, just so you know the pecking order of the people in charge, NCHS is part of the Centers for Disease Control and Prevention—CDC—which is part of CMS.

The ICD-10 7th character is determined based on whether the patient is undergoing active treatment. And therein lays one of the problems. When you ask a physician to define active treatment, he/she typically notes that it occurs over a period of time (an episode of care) being with the initiation of treatment [after evaluation], an ongoing treatment phase, and finally the discharge (that effectively ends "active treatment"). This clinical concept is reinforced through the global service definition associated with procedure coding that active treatment begins pre-op (at the time of the decision for surgery), includes the intra-op work, and ends after the conclusion of either a 10 or 90 day post-op period,

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That, however, is not how ICD-10 defines active treatment. ICD-10 guidelines state that "7th character 'A', initial encounter is used while the patient is receiving active treatment for the condition"—so far, so good; no argument there—Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician." Okay, now we have confusion.

Active treatment: surgical treatment means the intra-operative performance of services and procedures.

Active treatment: emergency department encounter means the treatment episode of care contained within and related to emergency department services.

Active treatment: evaluation and continuing treatment by the same or a different physician qualification is what leads to confusion. The makers of the guidelines should have inserted the word "active" to have it read, "…continuing active treatment by the same or a different physician." That would have helped. What would have helped even more is not to leave the definition of active treatment to 3 examples, but actually to define it. The definition of active treatment (and by extension, the character "A") should be the initiation of or continued treatment or encounter that is not follow-up for the injury (or for a poisoning or external cause or osteoporetic fracture or stress fracture or pathologic fracture). If it's follow-up (further observation or treatment following the active treatment), it's not active treatment. Whew.

Maybe I can help (or not) with some examples:

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• If a patient goes to an emergency department, and is evaluated and treated by the ED physician for an injury, the 7th character is an "A"—initial encounter, active treatment. [no confusion there]

• If the ED physician has a foot and ankle specialist come in and evaluate and treat the patient in the emergency department, the DPM applies an "A" to the injury ICD-10, just like the ED physician would. [no confusion there]

• If the ED physician orders x-rays to evaluate the extent of a patient's fracture, and the radiologist reads the film, producing a report, the radiologist would code the ICD-10 on his/her claim with an "A" because the evaluation and/or treatment of the fracture occurred during the emergency department episode of care (active treatment). [probably no confusion there]

• If a patient is admitted to a hospital for an injury to the ankle and the admitting physician calls in a foot and ankle specialist two days post-admission, if the DPM is performing active treatment and not follow-up care, he/she applies an "A" to the injury code. [the key is active treatment versus follow-up care]

What about "D"…
when is that applied?
"D" is defined as "subsequent encounter"

What about "D"… when is that applied? "D" is defined as "subsequent encounter", which I feel is better termed "follow-up to active treatment." ICD-10 defines it to be "used after the patient has received active treatment for the condition during the healing or recovery phase." Follow-up to active treatment fits. The ICD-10 guidelines help define this term, like "initial encounter" with the following examples (which appear random, at least to me): "cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury." I would have thought that "other aftercare and follow-up visits following treatment of the injury" was all you needed to say, but some obviously thought that it would be good to explain that pulling out a pin in a toe or removing a surgical screw is not active treatment, but follow-up to the original active treatment (the surgery). Okay, let's focus on the "D" character representing "after active treatment" routine follow-up services or follow-up related procedures. How about some more examples?

• If the ED physician examines and treats a patient for a laceration, and refers the patient to your office on Monday for follow-up [hint hint], when you see the patient for the first time for this condition (whether or not the patient is new or established to your practice), the injury ICD-10 code 7th character is "D"—huh? Why is it "D" (subsequent encounter) when you have never seen this patient before? It's because "assignment of the 7th character is based on whether or not the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time." You are seeing this patient in follow-up "after active treatment" was performed by the ED physician. Don't get this confused with your CPT E/M coding. This could be a new patient to your practice with you billing an initial E/M encounter code while ICD-10 diagnosed with a 7th character indicating a subsequent encounter. Agggrrrhh. Think in terms of the 7th character as telling data miners at NSA or the insurance company that you are following up the care of active treatment previously performed.

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• If you treated a patient for a fracture and the patient is re-appointed to return in 10 days for a cast removal and re-application, the ICD-10 injury code 7th character would be "D" (there is routine healing going on) even though in your mind you are thinking that you are still actively treating the patient. What you are, in fact, doing is following up the initial active treatment of the fracture. Consequently, it is "D".

• If a patient calls their primary care physician's office and reports that they just dropped a frozen turkey on their right foot, and they are seen and treated by their PCP and referred to you for follow-up, you would be billing a "D" as your 7th character on the injury code.

• If a patient calls their primary care physician's office and reports that they just dropped a frozen turkey on their right foot, but the PCP's office tells them to go to your office for care, when you see and actively treat them, it's an "A" [you and you alone are the one actively treating the patient for the condition].

• If you belong to a podiatry super group (7 docs), and one of

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your partner's patients with an established traumatic condition sees you because you are available for follow-up, you would code "D".

Some Concluding Points

Keep in mind that in ICD-10 world, the term "initial encounter" 1) has everything to do with active treatment (think of the surgery event—that moment in time—and not any follow-up which occurs afterward), 2) is not necessarily based on the first time you have seen the patient for the presenting condition, and 3) no relationship with the E/M service initial encounter definition.

Until somebody wakes up and NCHS-CDC-CMS suspends the need for 7th character codes (and laterality, as long as I am making wishes), they are in play. If you don't code to the highest level of specificity, and ICD-10 clearly lets you know if you need a 5 character code, a 6 character code, or a 7 character code, you will be summarily denied reimbursement. When it comes to the 7th character codes, you will find them in Chapter 19 (Injury, Poisoning, and Certain Other Consequences of External Causes), as well as Chapter 13 (Diseases of the Musculoskeletal System and Connective Tissue), Chapter 15 (Pregnancy, Childbirth and the Puerperium), and Chapter 20 (External Causes of Morbidity). Be prepared.

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.