ICD-10 & Report Format
Radiologist

There is speculation that after ICD-10 has been implemented insurance carriers will also enable additional edits on their end to deny unspecified codes for medical necessity. ICD-9 had approx. 13,000 codes; ICD-10 has expanded to 68,000 codes. Codes are more specified: site, laterality, severity (acute vs chronic/traumatic vs non traumatic), initial vs subsequent vs sequela for injuries, defining "history of" (current vs true history). This is more than just a "coder issue." If the documentation doesn't support the more specified code decrease in payments may occur. Claims submitted to insurance carriers with unspecified codes are at risk for denial or delay in payment (additional info requested).

Technologists, schedulers and coding staff have received training pertaining to how to obtain more specified indications/conditions. This information is easiest obtained at the time of scheduling or if necessary the tech may query the patient further and document pertinent information. Complete documentation should be available for your review. This information ultimately needs to be available for coding via the dictated report.

ICD-10 Documentation-Indications

Listed below are target areas that have been identified as needing further specificity than what is currently provided.

- R/O, suspected, questionable condition: Current signs or symptoms must be documented on the order.
- Preoperative exams: Must have reason for surgery listed as well as preop verbiage. Name of surgery is not sufficient; please provide clinical diagnosis precipitating surgery.
- "History of" verbiage: Only use term "history of" if condition does not currently exist. Additional signs/symptoms should be stated.
- Laterality: If applicable specify- right, left or bilateral
- Pain: Acute or chronic?
  Specific area of pain-Abdomen: specific quadrant
  -Chest: Precordial, pain breathing, throat pain, other/unsp chest pain
  -Limb: specific anatomic area of pain with laterality documented.
- Acute or chronic or neoplasm related: Please state status if known.
- Surgical films: Need to know why surgery was done, name of surgery will not provide a diagnosis code.
- Trauma, MVA, fall: Not sufficient for indication. Specific type (contusion, sprain, strain, fracture, laceration, etc) of injury and location affected.
- Follow-up, tube check, PICC line: State condition that necessitated the exam and if encounter is for aftercare?
- Neoplasms: Active vs "history of"(don't use history of verbiage to indicate a current active cancer).
  History: *Defined in the coding world* as: Treatment has ended and no follow up.
  (Primary site removed, no treatment, no evidence of malignancy)
  -Also specify mets: Primary and secondary specified. Mets to and mets from?
  -Purpose of encounter: Therapy vs evaluation?
  -Specify specific site of cancer in area or organ: quadrant/section/laterality

ICD-10 Documentation-Impression

Impression: Only list findings that are positive or negative findings (related to the indication) of exam in order of severity.

Fractures

- Status of care:
  1) Initial-pt sent from ER/surgery/under diag eval **2)** Subsequent-aftercare [routine or delayed healing] **3)** Sequela
- Laterality and location
- Pathological: due to neoplasm or other documented disease?
- Traumatic (displaced or non-displaced) (open or closed) (type of fracture)
- Non or malunion

Intracranial injury

- Concussion, cerebral edema, diffuse traumatic injury, unspecified
- Focal traumatic injury: contusion, laceration, hemorrhage or all/Specify area of brain
- Hemorrhage: epidural, subdural, subarachnoid
- Other injury specify area
- Note if LOC and time

Pneumothorax

- Spontaneous/Post-procedural/Traumatic (specify encounter-Initial subsequent sequela)
- Primary, Secondary (specify condition)
- Chronic
- Other air leak
- Other pneumothorax

Embolism/Thrombosis

- Acute or chronic
- Specify laterality and specific venous location

Osteoarthritis

- Primary/Secondary/Post Traumatic/Other
- Joint Location and laterality

Pleural Effusion

- Document if malignant>specify cancer (location/type)
- Document if related to other conditions>specify condition

Ascites

- Document if malignant >specify cancer
- Document if due to other disease>specify disease

Report format

Reports are "pre-coded" by computer assisted coding software prior to being reviewed by a PMM coder. This greatly improves turnaround time and consistency. This software is most successful with a consistent report format similar to the following:

- **EXAM-Number of views**
- **INDICATION-Include as much info as provided**
- **COMPARISON**
- **TECHNIQUE (WITH TYPE OF CONTRAST & AMOUNT ADMINISTERED/DISCARDED)-Contrast is billed out separately for Iowa Diagnostic sites, but the administered and discarded mls need to be documented.**
- **FINDINGS-Please include incidental findings here.**
- **IMPRESSION-Only diagnoses/findings that are directly related to reason for exam. If a significant incidental finding & follow up imaging is suggested it may be listed in the impression. Please list according to severity.**

- **Each report should be dictated separately**:
  -Increased number of exams not dictated occurs when combining reports.
  -IT interfaces will not send multiple reports across for Portable xray (Portable does not have ability to accept multiple accession #'s on one combined report).

- **Impression:** Only list findings that are positive or negative findings (related to the indication) of exam in order of severity. Significant incidental findings suggesting a follow up imaging or evaluation by a provider. Incidental findings should remain in the findings section of the report.