Dermatology Coding Changes With ICD-10

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Practice Points

- Continue vigilant preparation for the implementation of the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM),* even in light of the new deadline.
- Learning small coding changes slowly will make the transition less arduous.

Although implementation of the *International Classification of Diseases, Tenth Revision, Clinical Modification* (*ICD-10-CM*) has been postponed, do not feel an overwhelming sense of relief. It appears that *ICD-10-CM* is imminent, and this delay will give us more time to plan. Ideally, knowledge of the code changes will help dermatologists to document more appropriately within the confines of *ICD-10-CM*. Once the transition to *ICD-10-CM* takes place, the hope is to accomplish the intended goal of better epidemiological record-keeping in health care. Although a list of the codes and subcategories are in the *ICD-10-CM Tabular List of Diseases and Injuries*,[1] this column will serve as a primer on new codes as well as changes to some general codes that dermatologists should understand.

Codes With Increased Specificity

One of the key differences associated with *ICD-10-CM* is the increased specificity of the codes, which also has led to an increase in the number of required codes. To facilitate this increased specificity, previous catchall codes will be eliminated. It will not be possible to select a less specific code and move on. To receive reimbursement, specificity is required. Here are some examples. Under the *International Classification of Diseases, Ninth Revision* (*ICD-9*), the code for psoriasis is 696.1 and is a perfectly acceptable selection with *ICD-9*.[2] However, in *ICD-10-CM* psoriasis is its own category (L40), with the code for psoriasis vulgaris as L40.0, generalized pustular psoriasis as L40.1, guttate psoriasis as L40.4, and so on.[1] This example is straightforward and one might argue that you could easily select L40.0 for every patient with psoriasis but doing so could be problematic on the back end. Disease entities will be seen as subcategories that will be broken down even further with the addition of a numerical digit to the code. For example, arthropathic psoriasis will have a code of L40.5, but this disease entity may be further subcategorized as psoriatic spondylitis for more specificity, which would have a code of L40.53.[1]

Using Multiple Codes

Certain diagnoses will need to be described using more than one code. For example, when coding for certain processes that are thought to have an infectious process, we will need to code for the entity (eg, carbuncle, furuncle, abscess) in addition to the causative organism (eg, an abscess caused by methicillin-resistant *Staphylococcus aureus*).

Excludes1 and Excludes2

Excludes1 indicates that the code excluded should never be used at the same time as the code in the section above the note.[1] Excludes2 indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time, allowing for both codes to be assigned together. For instance, in *ICD-10-CM* acne is a category with the code L70.

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Acne conglobata is coded as L70.1 and infantile acne is coded as L70.4, and so on. An Excludes2 for acne is acne keloid, which is coded as L73.0. As a result, both codes (L70 and L73.0) can be billed at the same time.[1]

Conclusion

As I continue to describe the nuances of *ICD-10-CM* in this column, it is important to keep in mind that even the most daunting changes can be easy to incorporate into your daily practice. In fact, for more research-minded clinicians, many of the coding changes may actually improve the way we practice.

REFERENCES

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