ICD-10 Will Allow Dermatologists to Effectively Communicate With Payors About Patient Visits

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Practice Points

- With *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM),* dermatologists will have a more accurate way to communicate with the payor. For example, physicians will be able to code for scabies as well as the cause of postscabetic pruritus.
- Physicians will have the option of coding for the reason the patient presented. For example, dermatologists may code for a skin examination to screen for a malignant neoplasm.
- The reimbursement of the new codes has not been addressed; a head-to-head comparison will be needed during the testing period.

It is important that dermatologists do not overlook the changes associated with the transition to *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*. Some physicians believe that providing this level of specificity is not important because at the end of the day, who is watching? You will see with several of the codes highlighted in this column that specificity may be required before a claim can be submitted to the payor for processing. In addition, some older catchall codes will go away, forcing us to provide additional specificity.[1]

Scabies coding is a good example of an added specificity requirement. Currently, with the *International Classification of Diseases, Ninth Revision (ICD-9)*, we have a code for scabies but no code to address the postscabetic pruritus that patients often develop. The *ICD-9* code 133.0 applies to scabies, and if we would like to code for the itch, we must enter a second code for unspecified pruritic disorder (698.9).[2] With *ICD-10-CM*, we can be more specific and actually code for the cause of the itch. We will be able to mark the initial visit as B86 (scabies), but subsequent visits for the itch related to scabies can be coded as pruritus using the primary code L29.8 (other pruritus) and a new sequelae or late effect code of B94 (sequelae of other and unspecified infectious and parasitic diseases).[3] You will still be able to submit the second visit with scabies as the primary diagnosis, but this practice should be avoided to prevent claim rejection on the backend. In addition, there will be codes to allow for evaluation of a family member or close contact for this condition. Although coding these patients as an initial visit for scabies may be easier, for epidemiologic purposes a more complete code to provide would be the *ICD-10-CM* code of Z11.8 (encounter for screening for other infectious and parasitic diseases), particularly if they are not found to have scabies.[3] This code also would be useful when screening for head lice when a close contact is not found to have it.

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What do we currently code when someone comes for screening of head lice because a classmate or sibling has it? With *ICD-10-CM* we will have a more accurate way to communicate with the payor.

The increase in the number of codes with *ICD-10-CM* permits us to give a description on a situation or circumstance when a person who may not be sick comes into the office for a specific reason or when circumstances influence a person's health status but those circumstances are not an actual illness or injury. It is frustrating that I currently am not able to code for a skin examination appropriately using *ICD-9*. Let me be clear, I am not saying that this new code will be reimbursable. We will have to wait and see how we are reimbursed for all of these codes, but at least we will have the option of coding for the reason the patient presents to us, which is often a skin examination, and then the secondary code could be benign nevi or seborrheic keratosis. The code Z12.83 (encounter for screening for malignant neoplasm of skin) will now be the best code for these purposes.[3] In addition, codes that address postoperative nursing visits have not been available. With *ICD-10-CM* we will have a new code for encounter for surgical aftercare following surgery on the skin and subcutaneous tissue that does not include a standard suture removal but is a necessary visit (Z48.817). In addition, we will have a specific code to document encounters for allergy testing (Z01.82).[3] With *ICD-9*, rash not otherwise specified or eczema would have to be the primary code (782.1) and you were forced to place a code for the patient's allergy, regardless of whether or not the allergy was known.

The reimbursement of these codes has not been addressed, so ideally during the testing period there can be a head-to-head comparison. By adhering to some of the new rules, hopefully we will be able to more completely communicate about what is occurring during the patient visit.

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