ODG Best Practices for Multiple Diagnoses/Codes

ICD (International Statistical Classification of Diseases and Related Health Problems) is an international coding schema developed and managed by the World Health Organization (WHO), used by all 117 WHO member countries, with many of these members providing delegates to help work on the codes. https://www.who.int/standards/classifications/classification-of-diseases.

Each edition/version is referred to as a revision, and while the most current revision is ICD-11 (adopted 2019, effective January 1, 2022), most member countries are using the 10th Revision (either directly, or indirectly as a modified version), and a few are using the most current 11th Revision.

Various countries have adopted ICD-10 with modification to the base version to meet their unique needs. The US ICD-10 code set is referred to as ICD-10-CM, Clinical Modification, with the current release in October for 2022. Australia is referred to as ICD-10-AM and Canada is referred to as ICD-10-CA.

Why is ICD Important?

ICD is important because it provides a common language for recording, reporting, and monitoring diseases. This allows the world to compare and share data in a consistent and standard way – between hospitals, regions, and countries and over periods of time. It facilitates the collection and storage of data for analysis and evidence-based decision-making.

Who Uses ICD Codes?

Users include physicians, nurses, other providers, researchers, health information managers and coders, health information technology workers, policymakers, insurers, and patient organizations.

How Does ICD-10 Work?

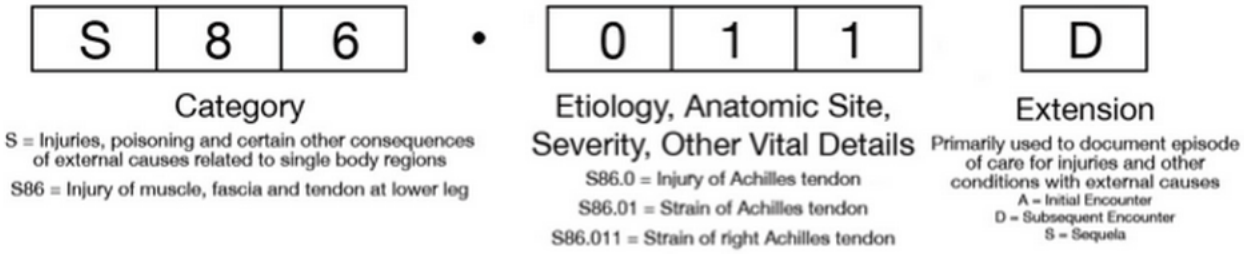
The current version of ICD-10 is effective from October 1, 2021 through September 20, 2022. The newest update/version will always begin on October 1.

The ICD-10-CM is broken into 21 chapters of Diseases and Injuries.

ICD-10-CM is a seven-character, alphanumeric code. Each code begins with a letter, and that letter is followed by two numbers. The first three characters of ICD-10-CM are

the “category.” The category describes the general type of the injury or disease. The category is followed by a decimal point and the subcategory.

Codes in the ICD-10-CM code set can have anywhere from **three to seven characters.** The more characters there are, the more specific the diagnosis. The first character is always alpha (i.e., a letter) and all characters two through seven can be either alpha or numeric.



ODG currently has the search functionality including ICD-9 and ICD-10 listed below:

Definitions

- “ODG Medical Topic” includes medical diagnosis, medical treatment, or anatomical body area.
- “ICD-9 (International Classification of Disease 9th Revision)” is a list of codes intended for the classification of diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.
- “ICD-10 (International Classification of Disease 10th Revision)” is a system used by physician and other healthcare providers to classify and code all diagnosis, symptoms, and procedures.
- “ICD-10-PCS (Procedure Coding System)” is a U.S cataloging system for procedural codes to track various health interventions taken by medical professionals.
- “CPT (Current Procedural Terminology)” is a coding system offering doctors across the country a uniform process for coding for medical services/procedures.
- “NDC (National Drug Code)” is a three-segment number that drugs are identified and reported by which serves as the FDA’s identifier for drugs.

- "HCPCS (Healthcare Common Procedure Coding System)" is a set of health care procedures based on the American Medical Association Current Procedural Terminology.

Using Diagnosis Codes in ODG

A Note on Consistency

For many claim situations there are often numerous methods and approaches for obtaining ODG data at the claim level. It is imperative to prioritize a consistent approach across the business.

While ODG provides a general framework and recommended concepts for utilizing the ODG content and leveraging the data consistently for maximum effectiveness, each stakeholder ultimately may leverage the data in a way they feel works best for them.

Whether using the ODG established guidance as the best practice approaches listed below or an alternative approach, ODG recommends each client utilize the adopted method consistently with the intent to provide the safest and most effective care possible.

Clients can mitigate ambiguity in claims handling by following standardization of best practice workflows. This increases uniformity of internal data for benchmarking and maximizes the benefits available using the ODG tools and solutions.

Multiple Diagnoses

ODG Best Practice for adding additional diagnoses is to include any condition that would reasonably be expected to have an impact on the injured workers' recovery and subsequent return to the pre-injury functional level.

ODG recommends attempting to limit inputs to a primary and secondary ICD if possible, rather than including all billed ICD codes, unless the billed ICD codes would reasonably be expected to have an impact on the injured workers' recovery and subsequent return to the pre-injury functional level.

Secondary ICD codes actively impacting recovery or lost time should only be entered once.

Although there may be multiple ICD codes for a specific condition, only one ICD should be entered. Entering all the relevant ICD codes for an injury (i.e., S83.242, S83.512,

M23.204 for a meniscus tear) would indicate there are multiple conditions when these are really all indicative of a single condition. To optimize ODG data, only a single ICD should be entered per active, relevant condition.

Multiple Surgeries

When working on a claim with multiple surgeries, the system won't differentiate when each surgery is. There are multiple ways to handle this. The ODG Best Practice recommendation is to enter the multiple surgeries together and then enter the Date of Surgery (populates in the Refinement Section when a surgery is pinned) for the procedure that has the longest disability duration.

If a subsequent surgery is performed beyond the initial goal RTW date corresponding with the durations of the initial surgery, or if there is a prolonged period between surgeries, then the ODG Best Practice Recommendation is to use one of two methods.

1. The first method is to simply use the date of the subsequent surgery to calculate Target RTW Date and Durations. This will ensure that all recovery times will be included in the date projections.
2. The second method is to determine the B Value Durations for the subsequent surgery alone, without multiple surgeries pinned, and use that as your goal or Target RTW Date.

We recommend continuing to use the A Value and M Value at the claim level with all surgeries included for accurate benchmarking.

When multiple surgeries are all related to the same underlying condition, ODG Best Practice recommendation is to include a single representation for the surgery. This is particularly important when using CPT codes as there are often many CPT codes for a single surgery.

Prospective Surgery Dates

For claims with upcoming surgeries, ODG Best Practice recommends not adding a prospective date of surgery until the surgery has occurred. Adding the tentative date of surgery could artificially inflate disability durations and related claim information.

For example, if the target disability duration for a claim is 10 days and the first date out of work is 1/1/21, then the target return-to-work (RTW) date would be 1/11/21. However, if a surgery with a disability duration of 90 days was planned for 3/1/21 and entered as such, that would inflate the disability duration of the claim by 49 days (the total duration from the initial target RTW date of 1/11/21 and the surgery date of 3/1/21).

Including prospective dates of surgeries can artificially inflate disability duration data and increase the likelihood of a disability mindset for injured workers from apparent extensive time off. For that reason, ODG Best Practice is to recalculate claim-level data when the surgery has been completed, which also eliminates artificially inflating the disability duration when the surgery is cancelled or changed.

Remember to pin the surgical procedure at the top once the surgery has been completed to receive an accurate RTW date.

Previous Surgery or Pre-Existing Injury

When there is a pre-existing surgery, unrelated and prior to the injury that resulted in lost time, the ODG Best Practice recommendation is to include the surgery if it would reasonably be expected to impact the recovery timeframe for the related injury(s) and if the date of injury is prior to the target return-to-work date for the pre-existing surgery. This can be calculated by entering the pre-existing surgery, the date of that surgery, and then comparing the target RTW date to the date of injury for the current condition that is resulting in lost time.

In an example where a claimant suffered a lumbar injury on 2/1/21 but had a prior lumbar fusion on 4/1/20, we recommend not including the surgery or surgery date as the fusion has a best practice duration of 140 days and this injury would have occurred outside of that timeframe. Rather, if the claimant continues to have residual deficits related to the prior surgery, we suggest adding the surgery confounding factor in the refinement section.

However, if the claimant had a low back injury on 2/1/21 but the prior lumbar fusion was on 12/1/20, that injury would have occurred within the 140-day best practice duration for the procedure. For this situation we would recommend still pinning the surgery and entering the surgery date as the impact of the lumbar fusion would still be relevant as the date of injury was only 62 days post-op.

Confounding Factors

Confounding factors, or comorbid conditions, do not need to be pinned as a primary diagnosis. Instead, they should be selected from the confounding factors listed in the search refinement section.

Any of the 9 factors should be checked when they would reasonably be expected to have an active impact on the injured workers' recovery, subsequent return to pre-injury functional level, or claim costs.

There is no need to add comorbid conditions/confounding factors unless they would actively be impacting a measurement of outcome.

Confounding factors

- ☐ Depression/PTSD/Psychosocial
- ☐ Legal Representation
- ☐ Opioids
- ☐ Preexisting Conditions
- ☐ Diabetes
- ☐ Obesity
- ☐ Substance Abuse
- ☐ Hypertension
- ☐ Smoker
- ☐ Surgery or Hospital Stay

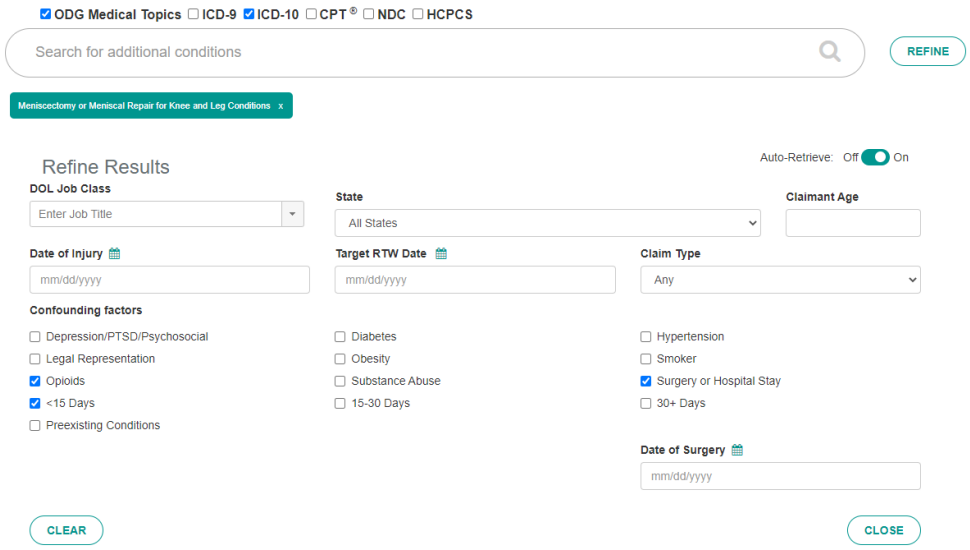
Conversely, if one of the above conditions is the primary or even secondary reason for the claim or lost time, then, instead of adding it as a confounding factor, it should be added as a pinned condition.

Conditions should not be redundantly added as both primary diagnoses and confounding factors as that will artificially inflate durations and cost data.

Surgery Confounding Factor

The “surgery” confounding factor should only be used if the surgery was recent and/or if the surgery (not the underlying pathology) is impacting return to work or recovery. This will be automatically checked when a surgical procedure is pinned as a primary factor, and a dialog box for the date of surgery will appear. This will allow for real-time return to work predictions based on the durations of the procedure. In addition, a pinned surgery will auto-check other relevant confounding factors like opioid use and the length of same.

See below for an example:



If a surgery is being performed within the typical course of treatment on a diagnosis (i.e., within the expected time frame from initial date of diagnosis at the discretion of the client), ODG recommends including both the surgery and the diagnosis as pinned conditions to evaluation durations and costs together.

If a surgery is being performed outside of the typical course of treatment (i.e., outside of what would reasonably be expected or if delayed due to a unique claim situation), ODG recommends only including the procedure itself as a primary condition. When a surgery is outside of the typical timeline of treatment, the claim will likely no longer require any treatment or lost time leading up to the surgery (as would be included with the pinned diagnosis) but would rather only need to evaluate the surgery and any subsequent post-op treatment.

Including both diagnosis and treatment when a surgery is outside of the typical care timeline could result in artificial inflation of duration and cost data.

Adding ICD Codes and Confounding Factors

Including a diagnosis code for a comorbid condition and selecting the same condition under the confounding factors, for example, obesity or age, will have a different impact on durations and risk scores.

If a confounding factor is checked at the claim level in the refinement section, this will retrieve the average for all claims with that confounding factor.

If a comorbid condition is pinned at the diagnosis level, this will retrieve the information for this condition for the duration and risk scores.

Each of these will bring back different results as they are pulling from two different areas. The confounding factor in the refinement tool is focused on claim data for that comorbid condition where pinning it as a diagnosis will bring back the duration for that specific condition.

It is recommended to select one or the other when refining claims information for duration and risk scores.

Refer to **Adding ICD codes for Confounding Factors** for an example.

Adding ICD Codes for Confounding Factors

Including diagnosis codes for comorbid conditions has a different effect on ODG data filtering than checking confounding factors or adding claim level information in the refinement section. It is important to understand when to pin a code and when to refine results for optimal leveraging.

If you enter the ICD-R54 (age related disability) you will see an impact on durations and therefore risk score, but this change is in addition to the input in the age field on the refinement section. It is important to note that both inclusions are distinctly different. The age field is related to the age of the claimant, comparing durations for a condition among similarly aged claimants.

If you pin a back sprain and enter age 60, ODG is going to retrieve the average for all back sprain claims among claimants aged 60. When adding the ICD-R54, it functions differently. ICD-R54 is a medical diagnosis used to indicate an aged related physical debility. Someone who is age 60 does not necessarily have an age-related physical debility. When this ICD is included it indicates that the age of the claimant is impacting the claimant's condition or recovery. Whereas entering the age of the claimant filters and retrieves data for claims with similarly aged claimants. As such, both the claimant's age and the use of ICD-R54 will have their own impacts on the claim durations and risk score.

Contact us at odghelp@mcg.com or 1-800-488-5548 for more information on ODG or to speak with the ODG Strategic Solutions team about obtaining a customized plan designed to meet the unique needs of your organization.