Proposed ICD-10-CM Diagnosis Coding for Lumbar Degenerative Disc Disease with and without Pain

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Introductory Remarks

➢ Thank you CDC/ICD-10 Group for providing ISASS with this opportunity to present a request for a new family of codes representing symptomatic 'discogenic' back pain with/without non-radicular (non-sciatic) sclerotomal (not dermatomal) leg pain.

➢ 'Radicular' leg pain might co-exist within the spectrum of disease but proper ICD-CM-10 codes already exist to define neuro-compressive lesions.

➢ Although one might wrongly consider applying 'disorder' as a band-aid to our request, Oxford Languages Dictionary appropriately defines the noun 'disorder' as a state of confusion; ISASS desires to remove confusion for coders, physicians, etc.

➢ ISASS is here at CDC/WHO for the third time now supported by AAOS & AANS to present yet once again in an open forum a proposal based on feedback from Dr Berglund on September 1, 2022 & October 20, 2022.

Current Coding Background

➢ AHIMA Standards of Ethical Coding dictates that one apply accurate, complete, and consistent coding practices [ICD-CM-10] that yield quality data.

   ➢ A case-in-point is the recent ICD-CM-10 code M54.51 which has been applied to vertebrogenic pain which was notably applied to the lumbar spine only, not the cervical/thoracic segments.

➢ There are no ICD-CM-10 sub-terms for 'discogenic' back pain. [Asymptomatic lumbar degenerative disc disease is non-noxious.]

Current Coding Background

➢ Lumbar disc degeneration (LDD) is not a definitive diagnosis therefore and merely represents at most a morphologic sub-grade of disc degeneration by the most widely known T2-based Pfirrmann grading scoring tool available for MRI survey interpretation of the lumbar spine.

➢ LDD coding was an appropriate standard when XRays were discovered by W. C. Röntgen in 1895. Restorative/Regenerative treatment measures address symptomatic dark disc disease, Pfirrmann grades 3-7 out of 8 grades.

➢ The degeneration process is a cascade, not a stable, static snapshot but rather a developing , dynamic changing presentation. Current inaccurate ICD-CM-10 codes for lumbar and lumbosacral degenerative disc disease do not draw a clear distinction between what is Problem Data and what is Health Concern Data and thus create a barrier of interoperability with confusion and a perceived overlap.

Current Diagnosis Standards

➢ The Physical Exam is how we currently diagnose either sciatica (an obscure, arcane term which has evolved from the 1600's) or radiculopathy by positive straight leg raise, Lasegue's sign, crossed Lasegue's sign, positive bowstring, positive femoral stretch test and motor/sensory/reflex change.

➢ Similarly, symptomatic lumbar discogenic disease is diagnosed clinically by axial midline back pain, pain with flexion, sitting intolerance, positive provocative with sustained hip flexion, absence of motor/sensor/reflex change, and positive discography.

➢ Discography, a minimally invasive test used since the 1950s in the US, confirms the origin of the back pain by either reproducing (diagnostic discogram) or relieving the pain (anesthetic discogram).

➢ This simple clinical test is not only essential prior to disc treatments but more importantly, has been used for decades to confirm a diagnosis of discogenic pain and differentiating it from other pain generators.

Pain Patterns

Radicular Pain[1]
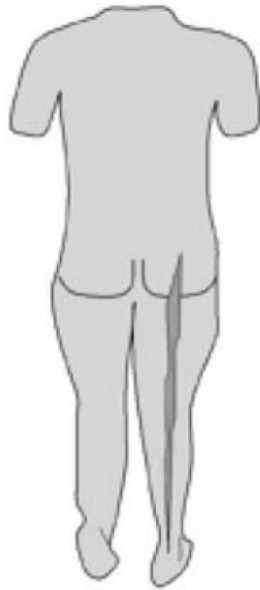
The pain evoked is distinctive. It has a lancinating quality, and travels along the length of the lower limb, in a band no more than 2–3 inches wide. The numbness is dermatomal in distribution and the weakness is myotomal. However, radiculopathy is not defined by pain. It is defined by objective neurological signs

(1) Bogduk, N. 2009. *Pain*. 147: 17-19.

Pain Patterns

Sclerotomal / Somatic Pain[1]

L3   L4   L5   S1
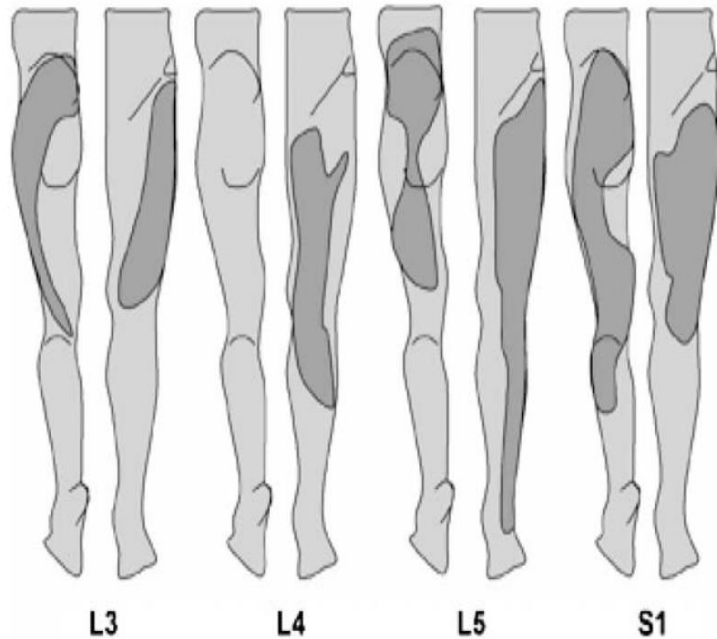
Somatic referred pain is dull, aching and gnawing, and is sometimes described as an expanding pressure. It expands into wide areas that can be difficult to localize. Once established, it tends to be fixed in location. Subjects often find it difficult to define the boundaries of the affected area but can confidently identify its center or core. Since somatic referred pain is not caused by compression of nerve roots, there are no neurological signs.

(1) Bogduk, N. 2009. *Pain*. 147: 17-19.

Lumbar Degenerative Disc Disease with and without Pain Coding Proposal

- The objective of the ISASS proposal is to generate specific codes for describing pain associated with lumbar and lumbosacral degenerative disc disease.

- Current pain codes do not address the various sources of chronic low back pain (CLBP). CLBP has 6 sources: (1) discogenic, (2) facetogenic, (3) neurocompressive including herniation and/or stenosis, (4) sacroiliac, (5) vertebrogenic, and (6) psychogenic. All of the sources have well defined ICD-CM-10 codes except for discogenic which has NONE.

- As noted earlier, the vertebrogenic source of pain was recently granted ICD-10 M54.51 for the lumbar spine only, NOT cervical/thoracic. Neither cervical/thoracic spine involvement is anatomically capable of manifesting symptoms with low back and/or radicular/dermatomal OR non-radicular/sclerotomal pain in the legs.

Benefits of New Codes

- **Overall, having specific codes will improve coding precision for lumbar degenerative disc disease with and without leg pain and thus lead to clinical assessment, better diagnosis and treatment strategies**

- **Because ICD-10-CM is both non-specific and/or out-of-date for LDD manifesting as LBP and/or leg pain, many of these services get identified by payers as either (1) investigational or (2) non-covered.**

- **Data collection supporting these services are flawed and under-reported leaving private carriers an opportunity to bias their own policy coverage such that profits are maximized while nuancing what is the rationing of spine care and/or shifting the costs downstream to Medicare.**

References

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