

# It's 2015 Coding Time!

By

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# Changes to CPT

- Change in Social History in an E & M code
- Importance of using the MDM in determining level of care
- Care Management Services
  - Including Complex Chronic Care Services
- New Behavior Code and revision to Developmental code
- New Fluoride Application
- New modifiers
- And other great stuff!!!!

# Medicare: Conversion Factor

- Remember ALL PAYORS listen to Medicare (CMS) when it comes to how to pay for a service.
- The conversion factor this year will remain the same until March 31, 2015
  - **Conversion Factor will be \$35.82**
  - If Congress does not intervene before April 1, 2015, the MPFS 2015 conversion factor for April 1, 2015 through December 31, 2015 will be **\$28.2239**.
  - Still want the conversion factor to be reduced at least 21%
  - You may see an increase in your payments if the RVU went up **HOWEVER** if they reduce the CF 21% they will decrease the amount using the CF.

# OIG now looking at Hospital Admissions and Place of Service Coding

- Watch your place of service coding for observation services.
  - If you admit to an outpatient hospital facility, make sure you use the **POS 22 NOT 11**
  - Watch what the hospital codes as they determine if the patient is inpatient or outpatient.
  - Office of Inspector General is watching these place of service codes very closely.
- Watch where you admit a patient
  - Inpatient/outpatient
  - If you expect the patient to be inpatient for only 2 days use the outpatient visit codes.
  - OIG found that many initial inpatient hospital stays should NOT have been inpatient.

# Changes to Social History

- A history contains 3 factors:
  - History of Present Illness
  - Review of Systems
  - And Past Medical, Family and Social History
    - Now Military History is considered part of the social history
      - It was added due to the growing emphasis on identifying those who serve in the military, have served or have a close relative (eg, parent) who serves because of the health implications that may have
    - Others for social history are school, day care, travel, activities, employment, drug or alcohol, tobacco use

# Medical Decision Making

- Many EHR's have caused practices to increase their level of care coding based on counting JUST history and exam and not taking into consideration the medical decision making
- CPT considered making the MDM a necessary element for each level of care
  - Currently can pick two of three for an established care visit: history, physical and MDM
    - Can be based on history and exam which is what most EHR's are using to determine level of care.
- Although did NOT do it this year may consider it for next year.
- LEARN what the MEDICAL DECISION MAKING really means!
  - Risk
  - Diagnosis
  - Data

# Medical Decision Making

- Most subjective part of coding
- Based on three factors
  - Risk
    - Presenting problem(s)
    - Diagnostic Procedure(s) ordered
    - Management Options Selected
  - Number of Diagnoses and/or Management Options
  - Amount and/or Complexity of Data to be reviewed
- **Two of three must match or exceed for a given level**



# Risk of Complications

Level of Risk	Presenting Problems	Diagnostic procedures	Management options
<b>Minimal</b>	<b>1 self limited</b>	<b>Lab test-veni punct.</b>	<b>Bandages / rest / drsg</b>
<b>Low</b>	<b>2 or more self limited 1 stable chronic illness Acute uncomp. illness or inj.</b>	<b>Superficial needle bx Lab test- art punc Single x-ray Physiologic tests</b>	<b>OTC drugs Minor surgery OT</b>
<b>Moderate</b>	<b>1 or more chronic illness with mild exacerbation 2 or more stable Acute illness with systemic sympt. Acute comp. inj. Undiag. New prob. With uncertain prog.</b>	<b>Multiple x-rays Deep needle bx LP, joint asp. CT, MRI Cardio imaging</b>	<b>Minor surgery with risks Elective major surgery Prescription Drugs Closed tx of fx</b>
<b>High</b>	<b>1 or more chronic with severe exacerbation Acute illness with threat to life/limb Abrupt change in neurologic status</b>	<b>Discography Myelography arthrogram</b>	<b>Elective major surgery with risks/ER major surgery Parenteral controlled substance/Drug therapy with intensive monitoring DNR</b>

# Risk Table

- Minimal (straightforward):
  - 1 self limited (splinter) simple sprain
  - Bandages, rest
- Low:
  - 2 self limited- diaper rash/runny nose
  - 1 stable chronic- asthma, well controlled
  - Acute problem-URI/Bronchitis/Pharyngitis
  - OTC drugs/x-ray/art. Lab/
- Moderate:
  - Asthma exacerbation/comp fx /2 or more chronic stable problems
  - Prescription drugs/CT/MRI/closed fx tx
- High:
  - Severe exacerbation of chronic cond
  - Threat to life or limb

**Two out of three elements must be met or exceeded for a given level of Medical Decision Making**

Risk of complications	Number of DX and/or mgmt options	Amount and / or complexity of data to be reviewed	Level of MDM
<b>Minimal</b>	<b>(PTS / ITEMS)</b> 1 pt Minimal 1 self limited 1 est. problem	1 pt Order and / or review lab 1 pt Order and / or review radiology test	
<b>Low</b>	2 pts Low 2 self limited / minor 2 est. problems 1 est. worsening 1 stable chronic	1 pt Order and / or review other tests- EKG / PFT 2 pts Direct visualization and independent review of image/tracing or spec.	
<b>Moderate</b>	3 pts Moderate 1 new prob. w/o add. work up 3 established problems 2 est. problems, one worsening	1 pt Decision to obtain old records and / or history other than pt 2 pts. Review & summarize old records and / or obtain hx other than pt	
<b>High</b>	4 pts High 1 new problem w/add work up 4 established problems 2 established prob. worsening Total Points _____	2 pts. Discuss case with other health care provider  Total Points _____	
<b>Minimal</b>	1 pt Minimal	< 1 pt Minimal	<b>Straightforward</b>
<b>Low</b>	2 pts Low	2 pt Low	<b>Low</b>
<b>Moderate</b>	3 pts Moderate	3 pts Moderate	<b>Moderate</b>
<b>High</b>	4 pts High	4 pts High	<b>High</b>

# Diagnosis Table

- Point system:
  - 1 point: straightforward/2 pts low/3 pts mod and 4 pts high
    - **STFD**: resolved OM (no further tx); rash (no tx) basically an illness or inj without any treatment, just watch
    - **Low**: Recurrent OM (RX); asthma stable; URI/Fever (no tx);
    - **Moderate**: Strep (new problem); Asthma exacerbation and hypoxia; Fever and Pneumonia; Abd. pain and vomiting (or just abd pain new problem); new ADHD no further w/u;
    - **High**: Abd pain with further testing not done in office; asthma exacerbation with hypoxia and tachypnea ; Respiratory distress (adm to hosp); New onset of diabetes with further w/u; New ADHD dx with fur. w/u

# Data Table

- Point system:
  - 1 point: straightforward/2 pts low/3 pts mod and 4 pts high
    - **STFD or 1 point:** Order a strep test or order an x-ray or EKG or PFT review a lab test or x-ray different than date of order
    - **Low or 2 points:** Look at an x-ray (direct observation) or discuss case with other provider );
    - **Moderate or 3 points:** Order lab or x-ray and direct observation of an EKG;
    - **High or 4 points:** Order lab and x-ray and discuss case with other provider

# Time as a Key Factor

- Time can be used as the key factor when: counseling constitutes more than 50% of the visit in face to face contact with the patient/parents.
- Physician has to document the amount of time spent in this discussion period and what was discussed.
- Total time spent for New Patient Visit, Established Patient Visit, Consultations:
- **Pick the code that is closest to the time noted**

99201: 10 min

99212: 10 min

99241: 15 min

99202: 20 min

99213: 15 min

99242: 30 min

99203: 30 min

99214: 25 min

99243: 40 min

99204: 45min

99215: 40 min

99244: 60 min

99205: 60 min

99245: 80 min

# Example of Time as a Key Factor

- HX: c/o cough, no fever. Appetite good
- PX: General, ENT, Resp, Card
- MDM: URI-symptomatic symptoms
- As Mom was leaving she broke out in tears, stated her and her husband were getting a divorce and she didn't know how to talk to the kids
- Talked at length in counseling about how to talk to the children, getting counseling herself
- Total time in visit: 35 min with >25 min spent in last part of visit counseling her divorce situation.

# CMS (Care Management Services)

- **New code 99490**
  - Chronic care management services at least 20 minutes of clinical staff time (**now designated as an RN, LPN or MA**) under the supervision of a physician or qualified healthcare provider with the following required elements:
    - 2 or more chronic conditions expected to last at least 12 months or until death
      - Such as Asthma and Diabetes
    - Significant risk of death, acute exacerbation, decompensation, or functional decline.
  - reimbursement would be \$40.39 by Medicare
  - ONLY code that CMS recognized with an RVU value of the Care Management Services
  - Billed once a month
  - Billed by a single physician but **only includes clinical staff time**, no physician time.
  - If multiple staff members are working on the case at the same time, only count the time associated with one staff member



# Care Management Services

- These services may include establishing, , implementing, revising, or monitoring the care plan, coordinating the care or other professionals and agencies.
- A care plan must be documented and shared with the caregiver and or patient.
  - Comprehensive plan of all health problems
  - May include
    - Problem list, expected outcome and prognosis, treatment goals, symptom mgmt., interventions, med mgmt., social services,
- Billed once a month by a single provider
- Only includes the clinical staff time.

# Complex Chronic Care Coordination

- **99487**: Complex chronic care coordination services; **first hour** of clinical staff time directed by a physician or other qualified health care professional with **NO** face to face visit, per calendar month
- **99489**: each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
  - CAN include physician time that is involved in coordinating the care of the patient
  - Only billed 1 X per month and **HAVE** to have a minimum of 60 minutes for the first hour

# Complex Chronic Care Coordination

- **Cannot report these codes if the plan of care is not changed in a month (or care plan is changed minimally)**
- Involve clinical staff developing, substantially revising and implementing a care plan under direction of the physician or other qualified health care professional.
  - Revision to a care plan will or could occur when the pt's clinical condition changes significantly
    - Identification of a new problem, new interventions, exacerbation of existing problem, and further education to patient and/or caregiver
- Pediatric pt's usually (but not always!) receives 3 or more therapeutic interventions (meds, nutritional support, respiratory support); have 2 or more chronic continuous or episodic health conditions expected to last at least 12 months or until death.
- The office must have the capabilities:
  - 24/7 access to care providers
  - Standardized methodology to identify pt's who require chronic complex care coordination services
  - Have an internal care coordination process/function
  - Use a form and format in the medical record that is standardized within the practice
  - Be able to engage and educate pt's and caregivers as well as coordinate care amount all service providers as appropriate for each pt.



# Advance Care Planning

- **99497:** Advanced care planning including the explanation and discussion of advance directives such as standard forms by the physician or other qualified healthcare professional, first 30 min; face to face with the patient and the family members and or surrogate.
- **99498:** each additional 30 min.
- **No published RVU's**
  - Face-to-Face service by a physician or other qualified health care professional with a patient, family member or surrogate:
  - To discuss advance directives w/ or w/o completing relevant legal forms
  - Reported based on time spent in advanced care planning
- May be reported with another E & M code like office visits if there is an additional management problem
- May NOT be reported with critical care codes or codes having to do with critical care services.
- **An Advanced Directive is:**
  - A document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity.
  - Examples include: Living Wills, Medical Orders for Life Sustaining Treatment or Durable Power of Attorney

# New and Revised Vaccines

- **Vaccines are updated twice a year**
- New:
  - ⚡ **90630** Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
  - ⚡ **90651** Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use
  - ⚡ **90697** Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
  - ⚡ **90620** Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use
  - **90621** Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for IM use
    - **The new meningococcal vaccine Trumenba (reported with CPT code 90621) has received FDA approval, however ACIP recommendations are not out and the code is not being implemented by CPT until February 1, 2015**
- Revised:
  - **90721**: DTaP/Hib
  - **90723**: DTaP-HepB-IPV
  - **90734**: Meningococcal quadrivalent for IM use
    - Capitalized the letter “T” in the term DTaP in codes 90721 and 90723
    - Lower-case the letter “h” in the term, “hepatitis B” in code 907223
    - relocate the placement of the word “inactivated” in code 90723
    - Revise code 90734 to describe a quadrivalent as opposed to a tetravalent vaccine.
- Most recent updates for vaccines are found at:
  - **<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page>**

# New Developmental Code for 2015

- **96127**: Brief emotional and behavioral assessment (eg: depression inventory, attention-deficit disorder/hyperactivity (ADHD scale) with scoring and documentation, per standardized form
  - **New code was added to differentiate those instruments that look solely or mainly at behavioral and/or emotional issues. These may include ADHD/ADD, inattentiveness, depression or anxiety**
    - **GAPS** questionnaire (Guidelines for Adolescent Preventive Services Questionnaire)
      - Used between ages 11-21
      - <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>
    - **SDQ** (Strengths and Difficulties Questionnaire)
      - The SDQ is a brief, free-of-charge, questionnaire consisting of 25 items assessing positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, and prosocial behavior). It takes 5-15 minutes to administer.
    - **ASAS** (Australian Scale for Asperger's Syndrome)
    - **ASQ:SE**: Ages and Stages Questionnaire: Social-Emotional
    - **Vanderbilt**
    - **Connors**
    - **BREIF**: Behavioral Rating Inventory of Executive Function
    - **PHQ-2 or PHQ-9**: Patient Health Questionair
    - **BASC-II** (Behavioral Assessment Scale for Children)
    - **PSC**: Pediatric Symptom Checklist
  - Payment is low: only has an RVU of .15 so payment is about \$5.37

## Clinical Attention Problem Scale

Please complete once a week

Child's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Completed by: \_\_\_\_\_ Medication: \_\_\_\_\_

Below is a list of items that describe pupils. Rate each item that describes the pupil *now* or *within the last week as follows:*

**0 = Not true      1 = Somewhat or Sometimes True      2= Very or Often**

**True**

**Morning**

1. Fails to finish things he/she starts.....	0	1	
2. Can't concentrate, can't pay attention for long.....	0	1	2
3. Can't sit still, restless, or hyperactive .....	0	1	2
4. Fidgets .....	0	1	2
5. Daydreams or gets lost in his/her thoughts.....	0	1	2
6. Impulsive, or acts without thinking .....	0	1	2
7. Difficulty following directions .....	0	1	2
8. Talks out of turn .....	0	1	2
9. Messy.....	0	1	2
10. Inattentive, easily distracted.....	0	1	2
11. Talks too much.....	0	1	2
12. Fails to carry out assigned tasks .....	0	1	2

**Afternoon**

1. Fails to finish things he/she starts .....	0	1	2
2. Can't concentrate, can't pay attention for long.....	0	1	2
3. Can't sit still, restless, or hyperactive.....	0	1	2
4. Fidgets.....	0	1	2
5. Daydreams or gets lost in his/her thoughts.....	0	1	2
6. Impulsive, or acts without thinking.....	0	1	2
7. Difficulty following directions .....	0	1	2
8. Talks out of turn .....	0	1	2
9. Messy.....	0	1	2
10. Inattentive, easily distracted .....	0	1	2
11. Talks too much .....	0	1	2
12. Fails to carry out assigned tasks .....	0	1	2



# Developmental Screening

- **96110:** Developmental Screening (eg: developmental milestone survey, speech and language delay screen), per standardized instrument
  - Revised: use to state ‘with interpretation scoring and report documentation, per form’
  - .28 RVU –pmts vary usually around \$9-\$25
  - Most Carriers follow Bright Futures recommendations on timing
    - Typical standardized instruments:
      - **MCHAT**
        - » 18 mo., and 24 mo up to 36 months
      - **ASQ** (Ages and Stages)
      - Early language milestone screen
      - **PEDS:** Parent’s Evaluation of Development Status

# Fluoride Application

- **99188** Application of topical fluoride varnish by a physician or other qualified health care professional
  - Used during preventive care
  - Some state Medicaid plans may continue to use the **CDT** codes that have been used previously
  - Do not replace those CDT codes with this new CPT code unless otherwise directed by your Medicaid plan
  - Code 99188 was not valued on the MPFS and therefore was published with 0.00 RVUs
  - Private payers plans *may* choose to pay

# Modifiers used with E&M Codes

- **25:** Used to indicate the Eval/Mgmt. service is a separately identifiable service (minor procedure)
  - Used only on visits to let the carriers know that on that day the provider determined that a minor procedure needed to be performed
- **57:** Used to indicate that the Eval/Mgmt. service was done to determine the need for surgery (major procedure)
  - Used only on visits to let the carriers know that on that day the provider made the decision that a major procedure was needed and it is the preoperative visit.
- **24:** Used to indicate that the Eval/Mgmt. service was unrelated to a major procedure
  - Only use this modifier on visit codes when there has been a major procedure (like a fracture) performed within the 90 days of that service. It indicates that it should be paid and is not part of the postoperative period.

# Modifiers for Procedures

- **59:** Used to indicate that the procedure is a distinct service
  - Use this modifier on a procedure that typically tends to get bundled into another service. This modifier will allow the over-ride of a bundling edit.
- **76:** Used to indicate that the same procedure was performed on the same day by the same physician on the same patient
  - This modifier only is used on a procedure to let the carriers know that more than one service of the same kind was performed that day and both (or more) should be paid separately
- **50:** Bilateral procedure
  - **69210 now is unilateral, if doing both ears use this modifier**
- **53:** Discontinued procedure
  - Indicates to the carrier that a procedure was started but for some reason had to be discontinued before the procedure was completed.
  - Do not reduce your fee, some carriers will reduce it for you by 25%
- **52:** Reduced service
  - Indicates to the carrier that the procedure was not as complex as listed in CPT
  - Do not reduce your fee, some carriers will reduce it for you by 25%



# What About Those Procedures!

- 2 types of procedures
  - Minor: have 0 to 10 days postoperative care
    - Does NOT include the office visit
      - If office visit performed to determine need for procedure bill visit separately
      - **There will be NO GLOBAL DAYS for minor procedures starting in 2017!!!**
    - Major: have 60 to 90 days postoperative care
      - Also does NOT include the office visit
        - If office visit performed to determine need for procedure bill visit separately
        - **There will be NO GLOBAL DAYS for major procedures starting in 2018**
  - Have to have a separate documentation for both services
  - Only major procedures for primary care are fracture care

# Bundling Edits

- NCCI edits can be found at [www.cms.hhs.gov](http://www.cms.hhs.gov)
- You can download these “bundling edits” for free
  - Lets you know what you can and cannot bill together on a claim
  - Only applies to Medicare but gives you a good idea what you can and cannot “fight” in denials from other carriers
- At the same site you can find the assigned post-op days to the procedures
  - Minor procedures are assigned 0-10 days
  - Major procedures are assigned 90 days (some carriers use 60 days)
  - Services rendered during the post op period that are related to that procedure are “included” in the procedure itself and are not billable.
- **Code 1 = use modifier to over ride edit.**

# NCCI Edit

90460	99212		20130101	*	1
90460	99213		20130101	*	1
90460	99214		20130101	*	1
90460	99215		20130101	*	1
90460	99241		20130101	*	1
90460	99242		20130101	*	1
90460	99243		20130101	*	1
90460	99244		20130101	*	1
90460	99245		20130101	*	1



# Documenting that Procedure

- When documenting a procedure be sure to “separate the procedure” from the visit itself
  - Many times the procedure will be ‘wrapped’ into the exam, this is not acceptable
    - IE: The procedure was explained to the Mom as appropriate and Mom shows understanding. The child laid on his left side and using a curette, a large amount of impacted wax was removed from the left ear. There was no injury to the ear and the child tolerated the procedure well.

# Minor Procedures

- **20600:** Arthrocentesis: bursa or small joint (\$44)
- **20605:** “, intermediate joint (\$61)
- **20610:** “, large joint (\$56)
- **10060:** I & D abscess, simple (\$86)
- **11730:** Avulsion of nail plate, partial or complete, simple, single (\$73)
  - **11732:** each additional nail plate
- **11740:** Evacuation of subungual hematoma (\$37)
- **17250:** Chemical cauterization of granulation tissue (\$78)
- **10120:** FB subq tissue via simple incision (\$114.75)
  - Includes removal of splinters when physician has to go beneath the skin to remove splinter
- **28190:** FB-foot (\$196.76)
- **30300:** FB-nose (\$180.76)
- **11200:** Skin tag removal; up to 15 lesions (\$65.75)
- **41010:** Incision in the lingual frenulum to free the tongue (\$161)
- Application of splints:
  - Short arm splint (forearm to hand): static-**29125 (\$49)** dynamic-**29126 (\$58)**
  - Finger splint: static- **29130 (\$30.75)** dynamic-**29131 (\$39.25)**
  - Short leg splint (calf to foot): **29515 (\$54.50)**
  - **A4570:** Splint **S8450-S9452:** Splint, prefabricated for finger, wrist, ankle or elbow
- Strapping
  - Shoulder: **29240 (\$43)**
  - Elbow or wrist: **29260 (\$39)**
- **24640:** nursemaid elbow (10 day post op) (\$107.75)

# Application of Splints/strapping

- Applies when the cast/splint/strapping is an initial service performed without a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to a patient.
- Use these codes in addition to the E&M service.
- Can be used when there is no fracture care to be performed.
- Codes 29000 to 29590
  - IE: **29125**: application of short arm splint (forearm to hand); static
    - 0 global days    \$65.55
  - IE: **29130**: application of finger splint static
    - 0 global days    \$52.30

# Fracture Care

- **24640**: Subluxation of radial head
  - 10 day global: \$141.14
- **25500**: Closed Tx radial FX
  - 90 day global: \$276.19
- **26750**: Closed Tx distal phalanx fx
  - 90 day global \$185.92
- **28510**: Closed Tx toe fx
  - 90 day global \$127.17
- **28490**: Closed Tx great toe fx
  - 90 day global \$149.38

# Laceration Repair

- Laceration Repair
  - Simple – Single layer closure
    - (dermabond)**12001-12021 (000)** \$90-\$165
  - When more than one repair is done to the same body area, and same complexity - add up individual lengths and submit as one
    - Scalp, trunk, extremities <2.5cm **12001** NF- \$ 90.27
      - 2.6 – 7.5 cm **12002** NF: \$109.98

# Burn Treatment

- **16000**: Burn treatment/first degree
  - 0 global days: sun burn \$69.47
- **16020**: Burn treatment/debridement
  - 0 global days \$82.75
- **17250**: Chemocautery/granuloma
  - 0 global days \$80.60
- **30901**: Chemocautery/epistaxis
  - 0 global days \$96.72

# Bottom Line!

- Make sure procedures are appropriately documented
  - Not in the exam but separate
- Be sure you use a different diagnosis code for the visit and the procedure
  - Be as specific as possible when it comes to diagnosis coding
    - If an injury don't forget the E code as a secondary diagnosis.

Now Let's Talk Diagnosis Coding!

Now Now, No  
Crying!!!



# Do's and Don'ts for ICD-10

- Do Dual-code your charts internally and improve the specificity of physician documentation.
- Start using the more specific “verbiage”
- Do Work with your vendor to test with payers so you don't experience financial hardship after October 2015.
- Don't panic you can do this!!

# ICD-9 and ICD-10

- Continue to use ICD-9 until Oct 1, 2015
- Use ICD-9 even after Oct 1, 2015 if you have claims outstanding for Jan. to Sept. 2015 or before that time frame.
- **DO NOT** use ICD-10 even if you get a denial after Oct 1 if the service visit is before Sept 30, 2015
- Continue to be as specific as possible for all services

# Let's Talk Diagnosis Coding

- Use codes at the highest level of specificity
- Use more than one diagnosis as appropriate
  - Those that are pertinent to the visit for that date
- V codes can be for information only
  - IE: **V12.29 to V19.19**: personal history of...
  - **These will be Z codes for I-10 (Chapter 21)**
- V codes can be payable:
  - IE: **V70.0 General Medical exam; V20.2 for Well care for Children**
  - **These will be Z codes for I-10 (Chapter 21)**
- E codes have to be used when there is an injury, poisoning and certain other consequences of external causes.
  - E codes describe how or where something happened.
  - **These will be S and T codes for I-10 (chapter 19)**

# About Diagnosis Coding

- Need to understand that diagnosis coding HAS to be more specific
  - Learn the new language such as:
    - Acute suppurative left otitis media without spontaneous rupture of eardrum (382.00) NOT
      - Otitis Media, unspecified (**382.9**)
      - Using a 5 digit code is more specific than a 4 digit code.
    - Right upper quadrant abdominal pain (789.01)
      - Abd pain, unspecified site (**789.00**)
      - Both 5 digits but 789.01 more specific
    - asthma with acute exacerbation (493.92)
      - Unspecified asthma (**493.90**)
      - Again, both are 5 digits but 493.92 explains more about the complexity of the visit.

# How Will ICD-10 Impact Your Practice

- Realize that reimbursement will probably be held up for 4-6 weeks or more
  - No testing prior to ICD-10 with carriers will cause delay in payments
- Need to “retain” about 2-3 months of revenue to cover payroll, overhead etc. until payments flow normal again.
- Documentation is extremely important in regards to diagnosis coding in ICD-10.
- Poor diagnosis coding will result in reimbursement being reduced
  - Risk Adjustment to payments due in part to DX not used-esp. chronic issues not brought forward.
  - When billing higher levels of care providers HAVE to use specific diagnosis codes as well as multiple codes for a visit.
    - Try NOT to use unspecified.
    - Ok to use signs and symptoms if no definitive diagnosis.
    - Be sure to use different diagnosis codes for the visit and the procedure
      - EX: use injury to elbow for a visit when a patient has a nursemaid elbow and nursemaid elbow as the diagnosis for the procedure itself.

# ICD-10 Checklist-Are You Ready?

- Project Plan: gain an overall understanding of the impact of the update to the ICD-10 code set.
- Impact Assessment: create a list of all your practice's electronic systems and work flow processes that use ICD-9 codes today, both clinical and administrative and a list of vendors.
- Implementation: determine vendor update install, billing install, testing both internal and external
- Training: identify all staff who need to be trained on ICD-10
- Conversion and Monitoring: start using on Oct 1, 2015. watch for issues such as rejection codes and changes in reimbursement.

# How to Transition to ICD-10

- Encounters that take place *on or after October 1, 2015* are reported with ICD-10-CM codes
- Encounters that take place *before October 1, 2015* are reported with ICD-9-CM codes
- **You will have to run simultaneous systems of ICD-9 and ICD-10 until all your claims from before October 1, 2015 have cleared.**
- Review EMR's or billing programs to make sure they can support both ICD-9 and 10 concurrently
- Review contracts with health plans to see what additional information they need or what will be changing
- Update forms, documentation and internal processes
- **Continue to EDUCATE providers and staff!!!**
  - Encourage provider to document and use more specific codes
  - Less “unspecified” as some payers may not accept them in the future

# October 1, 2015 Diagnosis Coding!


- **Quick Step Reminders!**
  - Know your resources
  - Know your guidelines
  - Know how to code
  - Know how to document
  - Trust yourself-don't overthink it!!!!



# I-10 versus I-9

- I-9 has 14,000 codes
  - I-9 has 3-5 characters in length
  - Not as specific
- I-10 has 68,000 codes in everywhere except the US!
- We have 154,000 codes!!!
  - I-10 3 -7 characters in length
  - **Highly specific**
  - I-10 code structure
    - Characters 1-3: category
    - Characters 4-6: Etiology, anatomic site, severity, or other clinical detail
    - Character 7: Extension
      - S52 Fracture Forearm
      - S52.5 Fracture of lower end of radius
      - S52.52 Torus fracture of the lower end of radius
      - S52.521 Torus fracture of the lower end of the right radius
      - S52.521A “; initial encounter for closed fracture
  - Describes severity, laterality, dominant vs. non-dominant, intent and source

# Some Interesting Facts about ICD-10

- **Will need to refer to the guidelines at the front of book for special instructions**
- A hyphen at the end of a code indicates that additional digits are required
  - Acute sinusitis, unspecified (J01.9-)
  - Means there is another digit after the 9
- **X** is used as a placeholder character for future expansion-marked with a  check mark.
  - Sometimes X is included in the code
  - Other times if a code must be coded to the 7<sup>th</sup> digit and is subdivided into a fourth or fifth character the placeholder X must be added to the code even if the code has only 5 digits (See 7<sup>th</sup> Character below)
    - T74.2XX7

# 7<sup>th</sup> Digit Episode of Care

- **7<sup>th</sup> Characters**

- Certain I-10 categories have a 7<sup>th</sup> character.
- The applicable 7<sup>th</sup> character is required for all codes within the category, or as the notes in the Tabular List instructs.
- The 7<sup>th</sup> character **MUST ALWAYS** be the 7<sup>th</sup> character in the data field.
- If a code that requires a 7<sup>th</sup> character is NOT 6 characters, a placeholder X must be used to fill in the empty characters.
- The following 7<sup>th</sup> character extensions are to be added to each code for this category
  - A initial encounter: initial encounter is defined as the period when a patient is receiving active treatment for an injury, poisoning or other consequences of an external cause. An “A” may be assigned on more than one claim. For example, consider a patient seen in the emergency department (ED) for a head injury that first is evaluated by an ED physician. If the ED physician requests a CT scan that subsequently is read by a radiologist , and then you see them in follow up, the seventh character “A” is used by all three physicians and also reported on the ED claim. **The A is used for the entire period when the patient receives active treatment.**
  - D: subsequent encounter: Subsequent encounter (“D”): this is an encounter occurring **after the active phase of treatment**, when a patient is receiving routine care during a period of healing or recovery. For example, a patient with an ankle sprain may return to the office to have joint stability re-evaluated to ensure that the injury is healing properly
  - Q: sequela: is assigned for complications or conditions arising as a direct result of an injury. An example of a sequela is a scar resulting from a burn.

# Important Information

- Divided into 2 main parts-just like I-9
  - Index: an alphabetical list of terms and their corresponding codes
  - Tabular List: a sequential alphanumeric list of codes divided into chapters based on body system or condition.
- **Major Change:**
  - Excludes 1: a type 1 excludes note is a pure excludes note. It means “NOT CODED HERE!”
    - Means two conditions cannot happen at same time
    - Excludes 1 note indicates that the code excluded cannot be used with the code above it.
    - EX: congenital form versus acquired form of the same condition
  - Excludes 2: a type 2 excludes note represents “Not Included Here”
    - Indicates that the condition excluded is not part of the condition represented by the code BUT a pt may have both conditions at the same time.
    - When excludes 2 appears under a code it is acceptable to use both the code and the excluded code together, when appropriate

# More Interesting Information

- **Laterality:** condition occurs on the left, right or is bilateral
  - **H60.33 Swimmer's ear**
    - **H60.331 Swimmer's ear, right ear**    **H60.332 Swimmer's ear, left ear**
    - **H60.333 Swimmer's ear, bilateral**    **H60.339 Swimmer's ear, unspecified ear**
- Many conditions have an underlying etiology: you will see
  - **Code First**-the codes should be reported as the first listed diagnosis code
  - **Use Additional Code**-an additional code is required to explain the diagnostic statement.
  - Symbol is a + sign: code listed is to be used first along with additional codes to identify eg manifestations, source, place etc.
    - Burn upper limb unspecified degree    T22.00X+
    - External cause code to identify source, place and intent of burn
- **Sequela (late effects):** has no time limit
  - Generally 2 codes used, condition or nature of the sequela then the sequela code.
- If the purpose of a visit is to receive preoperative evaluations (pre-op clearance for surgery) report code Z01.81 then the condition.

# Let's Talk Otitis Media

- There are **36** otitis media diagnosis codes!
- Common code: 382.3-Otitis media, Chronic, suppurative (purulent)
  - **H66 Acute Suppurative and unspecified otitis media**
    - Incl: with myringitis
  - **H66.00 Acute suppurative otitis media without rupture of eardrum**
    - H66.001 Acute suppurative otitis media, right
    - H66.002 Acute suppurative otitis media, left
    - H66.003 Acute suppurative otitis media, bilateral
    - H66.004 ... recurrent right ear
    - H66.005 ... recurrent left ear
    - H66.006 ... recurrent bilateral
  - **H66.01 Acute suppurative otitis media with spontaneous rupture of eardrum**
    - H66.011 ... right ear
    - H66.012 ... left ear
    - H66.013 ... bilateral
    - H66.014 ... recurrent right ear
    - H66.015 ... recurrent left ear
    - H66.016 ... recurrent bilateral

# Now Asthma

- Currently most frequently used asthma diagnosis code used is **493.90** which is unspecified asthma or **493.00** which is unspecified extrinsic asthma although there are currently 14 asthma diagnosis codes!!!
- In ICD-10 there will be even more codes and more specificity will be required.
- ICD-10 wants to know if the asthma is mild intermittent , moderate, severe persistent, etc

# ICD-10 for Asthma

- Mild Intermittent
  - Uncomplicated: J45.20
  - Acute exacerbation: J45.21
  - Status asthmaticus: J45.22
- Mild Persistent
  - Uncomplicated: J45.30
  - Acute exacerbation: J45.31
  - Status asthmaticus: J45.32
- Moderate persistent
  - Uncomplicated: J45.40
  - Acute exacerbation: J45.41
  - Status asthmaticus: J45.42
- Severe persistent
  - Uncomplicated: J45.50
  - Acute exacerbation: J45.51
  - Status asthmaticus: J45.52
- Exercise Induced : J45.990
- Cough variant: J45.998



# Preventive Care: ICD-9 to 10

- V20.2                    Z00.110 Health Exam NBN under                    8 days  
                                  Z00.111            “ 8 to 28 days  
                                  Z00.121 Encounter for routine child health exam with abnormal findings  
                                  Z00.129 “ without abnormal findings
- V70.5 Exam for specific groups                    Z02.89
  - Z02.0    Preschool Children
  - Z02.0    Schoolchildren/Students
- V70.0 General Medical Exam (not child)
  - Z00.01 with abnormal findings
  - Z00.00 without abnormal findings
- Z01- codes for routine exams of specific systems like eyes + vision or ears + hearing
  - Also specify presence or absence of abnormal findings
  - Z01.00-Encounter exam eyes and vision w/o abn findings
  - Z01.01- “ with abnormal findings
  - Z01.10- Encounter exam ears + hearing w/o abn findings
  - Z01.110- Ear exam following failed hearing screen
  - Z01.118- Encounter for exam of ears + hearing with other abnormal findings
- Z11-Z13 and Z36- screening codes
  - Screening inherent to a routine exam
- Z23- Encounter for Immunizations
  - Any type of vaccine
  - Code first routine health exam
- Z28- Immunizations not carried out and for under immunized status
  - Z28.3- under immunized status

# Let's Do a Few Diagnosis Codes!

- Streptococcal sore throat: J02.0
- GERD, without esophagitis: K21.9
- Influenza with respiratory manifestations, other than pneumonia: J11.1
- Gastroenteritis, unspecified: K52.9
- Fever: R50.9
- Abdominal Pain, Rt Upper Quadrant: R10.11
- “ , Lt Upper Quadrant: R10.12
- “ , Rt Lower Quadrant: R10.31
- “ , Lt Lower Quadrant: R10.32
- “ , Periumbilic : R10.33
- “ , Epigastric : R10.13
- “ , Generalized: R10.84
- **V58.69: long term use of current medications (ADHD/Anti-reflux/Chemo)**
  - Z79.899
- V58.62: long term use of antibiotics
  - Z79.2
- V58.66: long term use of aspirin
  - Z79.82
- V58.64: long term use of nonsteroidal anti-inflammatories
  - Z79.1

# Signs and Symptoms

- Symptoms and signs involving emotional state
- [R45.0](#) Nervousness
- [R45.1](#) Restlessness and agitation
- [R45.2](#) Unhappiness
- [R45.3](#) Demoralization and apathy
- [R45.4](#) Irritability and anger
- [R45.5](#) Hostility
- [R45.6](#) Violent behavior
- [R45.7](#) State of emotional shock and stress, unspecified
- [R45.8](#) Other symptoms and signs involving emotional state
- [R45.81](#) Low self-esteem
- [R45.82](#) Worries
- [R45.83](#) Excessive crying of child, adolescent and adult

# Normal Newborn ICD-10

- **Z38:** Liveborn infants according to place of birth and type of delivery

- [Z38.0](#) Single liveborn infant, born in hospital
- [Z38.00](#) Single liveborn infant, delivered vaginally
- [Z38.01](#) Single liveborn infant, delivered by cesarean
- [Z38.1](#) Single liveborn infant, born outside hospital
- [Z38.2](#) Single liveborn infant, unspecified as to place of birth
- [Z38.3](#) Twin liveborn infant, born in hospital
- [Z38.30](#) Twin liveborn infant, delivered vaginally
- [Z38.31](#) Twin liveborn infant, delivered by cesarean
- [Z38.4](#) Twin liveborn infant, born outside hospital
- [Z38.5](#) Twin liveborn infant, unspecified as to place of birth
- [Z38.6](#) Other multiple liveborn infant, born in hospital
- [Z38.61](#) Triplet liveborn infant, delivered vaginally
- [Z38.62](#) Triplet liveborn infant, delivered by cesarean
- [Z38.63](#) Quadruplet liveborn infant, delivered vaginally
- [Z38.64](#) Quadruplet liveborn infant, delivered by cesarean
- [Z38.65](#) Quintuplet liveborn infant, delivered vaginally
- [Z38.66](#) Quintuplet liveborn infant, delivered by cesarean
- [Z38.68](#) Other multiple liveborn infant, delivered vaginally
- [Z38.69](#) Other multiple liveborn infant, delivered by cesarean
- [Z38.7](#) Other multiple liveborn infant, born outside hospital
- [Z38.8](#) Other multiple liveborn infant, unspecified as to place of birth

# Some Really Specific Codes

- R45.6: Violent Behavior
- F43.9: Reaction to severe stress
- Z56.6 : Other physical and mental strain from work
- OR Maybe
- T636.22A: Toxic effect of contact with other jellyfish, intentional self-harm, initial encounter
- V954.2XA: Forced landing of spacecraft injuring occupant, initial encounter
- V973.3XA: Sucked into jet engine, initial encounter