2014 ICD-9 Code Changes and ICD-10 for Urgent & Primary Care

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February 26, 2014
CHMB Corporate Overview

- **Founded in 1995**
  - Privately Held, Profitable and P.E. Funded for Rapid Growth
  - Inc. 5000 Fastest Growing Private Companies 2008-2012
  - Dell Partner since 2003
  - Fully Integrated 4 Acquisitions 2008-2011

- **Partners w/ Allscripts since 2007**
  - Early Adopter - Star Reference Site for EHR/PM/Implementation
  - Deeply Connected Across Multiple Disciplines
    1) Enterprise EHR/PM
    2) Hosting and Software Implementation/Training
    3) RCM Services

- **4,000 + Providers**
  - 300+ staff in 24/7 work-cycle
  - Locations – San Diego, Irvine, Oakdale and Chicago
  - Customers Located Across 4 U.S. Time Zones
  - Remote Workforce – 15 Different States

- **Largest Install of Allscripts PM – End User Expertise**
  - 450 + PM Databases Built, Deployed and Supported
  - 7,500 + End-Users
  - 1,000 + physicians supported on EHR

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**Service**
- Customer Focused
- Completing “the last mile”

**Technology**
- Leading Technology
- Value Add Business Intelligence

**Results**
- End-to-End Solution
- Physician Hospital Alignment
CHMB Core Service Offerings

**HIT**
- PM/EHR Implementation
- Software Sales
- Hardware
- Application Support
- ASP/Hosting
- Software Development

**RCM**
- Billing Services
- Practice Management
- Reporting
- Credentialing
- Compliance & Auditing
- Coding
- Business Analytics
- Decision Support

**Consulting**
- Practice Formation
- Recruitment
- Practice Assessment
- Practice Valuations
- Payor Contracting
- PM Build, Implementation & Training
- Workflow
- Optimization
Putting Valuable Information Into The Hands That Matter

Performance Indicators
C., Mark (Internal Medicine)

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Work RVU Analysis

Productivity Calculation:

YTD Average wRVUs per Visit 1.12
YTD Average wRVUs per Business Day 24
Next Percentile 90%
YE wRVUs at next percentile 7,392 87%
Current YTD wRVUs 4,725
YE wRVUs for next percentile 2,665
Additional Visits per FTE per Bus. Day 5

YTD wRVUs Analysis
About Our Speaker

• 33 years of operations experience in the practice management field
• An approved Professional Medical Coding Curriculum (PMCC) instructor by the American Academy of Professional Coders (AAPC),
• Education in current procedural terminology (CPT) and Ninth Revision, International Classification of Diseases (ICD-9) coding
• Evaluation and Management Coding and documentation; and compliance planning
• Specializes in chart auditing and is credentialed as a CPMA (Certified Professional Medical Auditor) and CEMC (Certified Evaluation and Management Coder)
• AAPC Approved ICD-10 Instructor and fellow in ACMPE
• Serves on the Section Council Steering Committee of MGMA
A new subsection, guidelines, and 4 codes have been added for reporting consultation between a physician and a specialist, without the patient present, over the telephone or internet.

Two codes have been converted from Category III codes to report total body and selective head hypothermia in critically ill neonates

Guidelines for the Complex Chronic Care Coordination Services and Transitional Care Management Serves have been revised to clarify these services.
New E/M Section Codes

- 99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
- 99448 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
- 99449 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
Interprofessional telephone/Internet assessment and management service

- Between 2 professionals
  - Requested
    - by Primary or Attending
    - To a specialist of specific specialty expertise (consultant)
  - Without the need for the patient’s face-to-face contact with the consultant
  - Typically Complex/urgent situations where a ftf visit is not feasible (distance)
  - Should not be reported by the consultant if the call results in a transfer of care
  - Consultant should not have seen the patient in past 14 days
  - Cannot be billed more than once per week
Interprofessional Telephone/Internet Consultations

• Since Medicare does not pay for face to face Consultation codes,
• And does not pay for any services that are not face-to-face
• It is not likely that Medicare will pay for these new codes
• Check your payer contracts (BCBSRI does not pay)
Inpatient Neonatal and Pediatric Critical Care

• These 2 new add-on codes have been included to describe total body and selective head hypothermia for critically ill neonates.

• Therapeutic hypothermia may be used to decrease mortality and improve neurodevelopmental outcomes for newborns with hypoxic ischemic encephalopathy (resulting from oxygen deprivation to the brain)
• +99481  **Total body systemic hypothermia** in a critically ill neonate **per day** (List separately in addition to code for primary procedure)

• +99482  **Selective head hypothermia** in a critically ill neonate **per day** (List separately in addition to code for primary procedure)

• May be reported in conjunction with 99291, 99292 (out-pt) , 99468 and 99469 (inpt per day)
Revised E/M Guidelines

• The Pediatric Critical Care Patient Transport guidelines were revised to clarify the types of services performed during a pediatric patient transport process.
• 99466-99467 describe complex services and include a list of services included in pediatric critical care and may not be reported separately.
• Any additional services not listed in the new guidelines should be reported separately.
Revised E/M Guidelines

• Complex Chronic Care Coordination Services 99487-99489
  – May only be reported by the single physician or QHP who assumes the care coordination role with a particular patient for the calendar month
  – The face to face (ftf) and non-ftf time spent by the clinical staff in communicating with the patient/caregivers
    • Only the time of the clinical staff of the reporting professional is reportable when two or more are meeting about the patient
    • 99487-99489 may not be reported if the care plan is unchanged or required minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered)
Revised E/M Guidelines

• Transitional Care Management Services 99495-99496
• Extensive revisions to these guidelines due to expansion to include
  – TCM services are now applicable to new patients
  – Additional E/M reported separately should be on a subsequent date after the first f-t-f visit
  – Discharge service may not constitute the required face-to-face visit
  – TCM is not reportable in the postoperative period of a service by the same provider/surgeon
Revised E/M Guidelines

• 99238-99239 Hospital discharge day management
• To be reported only by the physician performing the discharge day management service.
• Other physicians or QHP providing concurrent services use subsequent hospital care codes (99231-99233) on the day of discharge
ICD-10 is Coming

• Greater Detail is required in the clinical notes to support code selections
• Refer to crosswalks to become familiar with the codes you use most frequently
CMS

- CMS: “On **October 1, 2014**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.”
  - One implementation for all covered by HIPAA (not applicable to Automobile Insurance, Worker’s compensation, some Liability Insurance)
  - CMS is firm – No extensions

Source:
ICD-9 Update - The Freeze is On!

• Because the compliance date for ICD-10 has been pushed back one year, the ICD-9-CM Coordination and Maintenance Committee, which includes an ACP representative, decided to also extend the partial code freeze by one year. There was considerable support for this partial, extended freeze.

• Here is the revised ICD-9 update schedule:
  – The last regular, annual updates to both the ICD-9-CM and ICD-10 code sets were made on Oct. 1, 2011.
  – On Oct. 1, 2012, only limited code updates were made to the ICD-10 code set to capture new technologies and diseases; no additions, deletions or revisions were made to the ICD-9-CM code set. Both code sets again received only limited code updates on Oct. 1, 2013.
ICD-10 Updates- the Freeze is On!

• October 1, 2014, there will be only limited code updates to the ICD-10 code set. There will be no updates to ICD-9-CM because it will no longer be used for reporting.

• On Oct. 1, 2015, regular updates to ICD-10 will begin.
Comparison of ICD-9 to ICD-10
Reimbursement and Quality Problems with ICD-9

• Example – fracture of wrist
  Patient fractures left wrist

• A month later, fractures right wrist
  – ICD-9-CM does not identify left versus right –
    • requires additional documentation
  – ICD-10-CM describes
    • Left versus right
    • Initial encounter, subsequent encounter
    • Routine healing, delayed healing, nonunion, or malunion
Comparison of Code Sets

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
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<tr>
<td>3-5 characters</td>
<td>3-7 characters</td>
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<tr>
<td>More than 17,000 codes</td>
<td>More than 155,000 codes</td>
<td><strong>68,000 are for ICD 10- CM</strong></td>
</tr>
<tr>
<td>First digit may be alpha or numeric (E or V only), digits are 2-5 are always numeric</td>
<td>First character is alpha; 2 &amp; 3 are numeric; 4-7 are alpha or numeric</td>
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<tr>
<td>Limited space for adding new codes</td>
<td>Flexible, new format allows for expansion</td>
<td></td>
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<tr>
<td>Lacks detail</td>
<td><strong>Very specific</strong></td>
<td></td>
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<tr>
<td>Lacks laterality</td>
<td>Includes a specific field to identify laterality (right vs. left)</td>
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ICD-10 Changes Everything

Detailed Clinical Information

- Episode of care
- Laterality
- Severity
ICD-10 Differences

- Combination Codes
- Laterality
- Episode of Care
- Exact Anatomic Location
- Clinical Details
- Cause/etiology
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication
  – Simplifies the number of codes needed to clinically spell out a condition
  – *Documentation will need to support all elements*
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
    K71.51 Toxic liver disease with chronic active hepatitis with ascites

• What additional documentation will be needed?
  ❑ Chronic, acute, subacute, persistent
  ❑ Active, Lobular, fibrosis, cirrhosis, necrosis
  ❑ With or without coma
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication

E11.21 Type 2 diabetes mellitus with diabetic nephropathy

What additional documentation will be needed?
- Hypersmolarity, □ with coma, □ with kidney complications, □ nephropathy, □ with CKD, □ with ophthalmic complications, □ neuropathy, □ circulatory complications, □ skin complications, □ arthropathy, □ oral complications
Laterality

• Code descriptions include designations for left, right and in many cases bilateral
• Documentation should always include laterality
• What additional documentation will be needed?
  - Right
  - Left
  - Bilateral
Laterality- Left versus Right

- C50.111 Malignant neoplasm of central portion of right female breast
- C50.112 Malignant neoplasm of central portion of left female breast
- C50.119 Malignant neoplasm of central portion of unspecified female breast
- Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.
Example:

- H61.12 Hematoma of pinna
  - H61.121 Hematoma of pinna, right ear
  - H61.122 Hematoma of pinna, left ear
  - H61.123 Hematoma of pinna, bilateral ears
  - H61.129 Hematoma of pinna, unspecified ear

- **What additional documentation will be needed?**
  - Right
  - Left
  - Bilateral
ICD-10 Structure

• The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity

• Characters 1-3 - Category ("Block")

• Characters 4-6 - Etiology, anatomic site, severity, or other clinical detail

• Character 7 – Extension (example- episode of care or other clinical detail)
Fifth/Sixth Characters

• Identifies the most precise level of specificity

• Example:
  – S55.011- Laceration of ulnar artery at forearm level, right arm

3 - S55 is a category for injury of blood vessels at forearm level
4 - S55.0 specifies the injury is at the ulnar artery at the forearm level
5 - S55.01 specifies it is a laceration
6 - S55.011 specifies it is of the right arm

• A 7th character extender is also required
Seventh Character Extenders

Examples:

A – Initial Encounter
D – Subsequent Encounter
S – Sequela - complications or conditions arising from the injury

What additional documentation will be required?

- Initial care (document active care)
- Subsequent care (document follow up or after care)
- Sequela (Provider must state the relationship is a late effect or residual effect)
Detailed Example

• S52 Fracture of Forearm
• S52.5 Fracture of **lower end of radius**
• S52.52 **Torus fracture** of lower end of radius
• S52.521 Torus fracture of lower end of **right** radius
• S52.521A Torus fracture of lower end of right radius, **initial encounter** for closed fracture
Example

• C15 Malignant neoplasm of the esophagus
  – C15.3 Malignant neoplasm of **upper third** of esophagus
  – C15.4 Malignant neoplasm of **middle third** of esophagus
  – C15.5 Malignant neoplasm of **lower third** of esophagus
  – C15.8 Malignant neoplasm of **overlapping lesion** of esophagus
  – C15.9 Malignant neoplasm of esophagus, **unspecified**

• **What additional documentation will be needed?**
  - Exact Anatomical Location
A Place for everything, everything in its place - Benjamin Franklin

- The fact that the codes are up to seven characters in length is a major difference that brings two new considerations: **seventh character extenders** and **dummy placeholders**.

- The seventh character extenders are usually a letter, and are used to identify the encounter type. The most common seventh character extenders used in ICD-10-CM are:
  - A- Initial Encounter for closed fracture
  - B- Initial encounter for open fracture
  - D- Subsequent Encounter for fracture with routine healing
  - G- Subsequent encounter for fracture with delayed healing
  - K- Subsequent encounter for fracture with nonunion
  - P- Subsequent encounter for fracture with malunion
  - S- Sequela
A unique twist- the “Placeholder”

- Some codes are 7 characters, but no 4\textsuperscript{th}, 5\textsuperscript{th} or 6\textsuperscript{th} place is necessary, so “x” is a placeholder

- **T68.xxxA** - Hypothermia

- The appropriate 7\textsuperscript{th} character is to be added to code T68
  - A – initial encounter
  - D – Subsequent encounter
  - S – sequela
Example

- A patient is treated for the first time for a pathological fracture.
  - M84.40 Pathological fracture, unspecified site, initial encounter for fracture
“Unspecified” Codes

• The Doctor has not given enough information in the documentation

• Differs from “Other specified” which means there is no exact code description for the documentation

• **Payers will not pay a claim with an unspecified code in many instances!**
It’s all about the Documentation

- The detail in ICD-10 depends on the information in the note.
- Coders and Billers are trained not to use “unspecified” codes.
- and are always directed to Query the Provider for more detailed information.
Clinical Documentation Improvement Goals

• Identify areas in ICD-10-CM that include new terminology for clinical documentation
• Define areas in ICD-10-CM that enable improved data capture if more specific conditions are documented
• Identify how documentation affects quality measure reporting and reimbursement
• Explain how to get buy-in from all the physicians in your practice
Why is Clinical Documentation Important?

- Documentation is critical for patient care
- Serves as a legal document
- Quality Reviews
- Validates the patient care provided
- Good documented medical records reduce the re-work of claims processing
- Compliance with CMS, Tricare and other payers regulations and guidelines
- Impacts coding, billing and reimbursement
Chapter Specific Guidelines

• Each Chapter has new guidelines listed in the front of the manual.

• Check the guidelines and become familiar with the guidelines for codes you use in your practice or specialty

• We will review some, but not all, coding guidelines and examples for Pediatrics and Urgent Care
Headaches

• Symptoms that signal the onset of a migraine are used to describe two types of migraine.
  – Migraine with aura (known as "classic" migraine)
  – Migraine without aura (known as "common" migraine)

• Status migrainosus refers to a rare and severe type of migraine that can last 72-hours or longer. The pain and nausea are so intense that people who have this type of headache often need to be hospitalized. Certain medications, or medication withdrawal, can cause this type migraine syndrome.
Chronic/Persistent

- **Chronic migraines** are classified by the International Headache Society as a migraine that occurs greater than 15 days per month for at least 3 months.
- **Persistent migraines** are migraines that last more than three months and occur daily from within three days of onset.
Chapter 8: Diseases of Ear and Mastoid Process (H60-H59)

• Chapter contains blocks: This chapter contains the following blocks:
  • H60-H62: Diseases of external ear
  • H65-H75: Diseases of middle ear and mastoid
  • H80-H83: Diseases of inner ear
  • H90-H94: Other disorders of ear
  • H95: Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified
    - The codes for reporting Complications of Surgical and Medical Care were reported in Chapter 17 in ICD-9 under Injury and Poisoning. In ICD-10 these codes are found in the system they relate to
Otitis Media

• Otitis media (OM) is any inflammation of the middle ear without reference to etiology or pathogenesis. OM can be classified into many variants on the basis of etiology, duration, symptomatology, and physical findings.
Acute/Chronic

- **Acute** suppurative otitis media is a sudden, severe inflammation of middle ear, with pus.
- **Chronic** suppurative OM is a chronic inflammation of the middle ear that persists at least 6 weeks and is associated with otorrhea through a perforated TM, an indwelling tympanostomy tube, or a surgical myringotomy
Chapter 10: Diseases of Respiratory System (J00-J99)

• Chronic Obstructive Pulmonary Disease [COPD] and Asthma
• Conditions included in this category include:
  – Asthma with chronic obstructive pulmonary disease
    • Chronic asthmatic (obstructive) bronchitis
    • Chronic bronchitis with airways obstruction
    • Chronic bronchitis with emphysema
    • Chronic emphysematous bronchitis
    • Chronic obstructive asthma
    • Chronic obstructive bronchitis
    • Chronic obstructive tracheobronchitis
EXAMPLE:

• A patient with COPD was admitted by her internist with a diagnosis of COPD with respiratory syncytial virus pneumonia
  – **J44.0** Chronic obstructive pulmonary disease with acute lower respiratory Infection
  – **JI2.1** Respiratory syncytial virus pneumonia
  – What additional documentation is needed?
    - Acute
    - Exacerbation
    - Type of infection
Asthma

• Asthma is a chronic lung disease in which the airways narrow and swell and produce extra mucus. It affects more than 25 million Americans. Asthma symptoms include coughing, wheezing, shortness of breath, and chest tightness. Asthma cannot be cured, just controlled.

• Coding for asthma has greatly expanded in ICD-10-CM to include intermittent, mild persistent, moderate persistent and severe persistent.
Diseases of Esophagus, Stomach and Duodenum (K20-K31)

• There are certain codes in this subcategory that require the use of an additional code to identify alcohol abuse and dependence (F10-) and additional documentation will be required in order to meet this level of specificity.

• If the note documents the use of alcohol as a cause of disease of the Esophagus, Stomach and Duodenum, use an additional code from F10 to identify the alcohol use and dependence

• **What additional documentation is needed?**
  - Alcohol use, abuse or dependence
EXAMPLE:

• Tim is being seen in treatment today due to vomiting with traces of blood. He has been a long time alcoholic and on a recent drinking binge. After endoscopy the surgeon notes he has Barrett's ulcer with hemorrhage exacerbated by his alcohol dependence.
  – **K22.11** Ulcer of esophagus with bleeding
  – **F10.20** Alcohol dependence without complication
Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)

• New ICD-10-CM Documentation Elements Related to Integumentary System Coding
  – Pressure ulcers
    • One code reports site and stage
    • More specific bilateral codes
    • Separate codes for abscesses and cellulitis
    • Separate codes for furuncle and carbuncle
    • Laterality
Skin and Subcutaneous Tissue

- New ICD-10-CM Documentation Elements Related to Integumentary System Coding
  - **Contact dermatitis**
    - Allergic
    - Irritant and substance cause
  - **Burns**
    - Identified by cause (e.g., heat, chemical)
    - Episode of care required
  - **Pressure Ulcers**
    - Decubitus ulcers
    - Bedsores
    - Bedridden patients
    - Stages I - IV
A 25-year-old male was working late at a mechanic’s garage when a robber came in to steal tools. The patient confronted the robber, who in turn threw battery acid on the patient and fled. The patient presented to the ED with battery acid burns on his chest by the collarbone, and had symptoms of redness, irritation, blisters, pain and numbness. The area of the burn was flushed with cold water and wet compresses were used to ease the pain. It was wrapped in a dry, sterile cloth. An antibiotic was given and the patient was told to follow-up with his regular physician for dressing changes.

- Code(s):
  - ICD-9-CM 942.32, 948.00, E961, E849.3, E000.0, E029.9
  - ICD-10-CM T54.2x3A, T21.71xA, T32.0, Y92.59, Y93.89, Y99.0
Pressure Ulcers

• Pressure ulcers are coded by stages.
• Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.

• What additional documentation is needed?
  - Exact location
    - Elbow (right or left)
    - Back (right upper, left upper, left lower, right lower)
    - Sacral region
    - Hip (right hip or left hip)
    - Buttock (right buttock or left buttock)
    - Contiguous site (back, buttock and hip)
    - Ankle (right ankle, left ankle)
    - Heel (right heel, left heel)
  - Stage (Stage 1 through Stage 4 or Unstageable due to eschar)

  - Note: Unstageable is not “Unspecified”
Unstageable Pressure Ulcers

• Assignment of the code for unstageable pressure ulcer should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.

• This code should not be confused with the codes for unspecified stage (L89.9-). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.9-).
EXAMPLE:

• A patient is treated for an unstageable pressure ulcer of the left buttock.
  – L89.320 Pressure ulcer of left buttock, unstageable
Non pressure ulcers due to underlying conditions

• Additional codes are necessary to fully describe the patient's condition for non-pressure chronic ulcers in ICD-10-CM. There are instructional notes under category L97 that state to code first any associated underlying conditions, such as atherosclerosis of the lower extremities, chronic venous hypertension, diabetic ulcer, or varicose ulcer. There is another note that states to code first any associated gangrene. The provider's documentation will drive what codes are able to be assigned.

• Non pressure ulcers are caused by underlying conditions. Code first the underlying condition as long as the provider has documented the relationship.
Example

- May is a type 2 diabetic. She presents to the office today with a diabetic ulcer on her left great toe. May does not inspect her feet on a daily basis, but does check them about once a week. The breakdown of the ulcer is limited to the skin.
  - E11.621 Type 2 diabetes mellitus with foot ulcer
  - L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
Chapter 21 Factors Influencing Health Status and contact with Health Services

• Z Codes Indicate a Reason for an Encounter
• Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed.
• For example, Z23 Encounter for immunization, requires a procedure code to identify the type of immunizations given.
Inoculations and Vaccinations

• Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given.
• Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.
EXAMPLE

• A six-month-old child came for her routine checkup. The patient is a very active, healthy child. During the encounter the physician determined the patient needed the suggested vaccinations.
  – Z00.129 Encounter for routine child health examination **without abnormal findings**
  – Z23 Encounter for immunizations

  – **What additional documentation is needed?**
    - Without abnormal findings
    - With abnormal findings
Status

• Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment.

• A status code is informative, because the status may affect the course of treatment and its outcome.
HIV

- Z20.6 Contact with and exposure to HIV
- Z11.4 Encounter for screening for HIV
- Z71.7 HIV Counseling
- Z21 Asymptomatic HIV infection status
HIV Example

• A healthy 33-year-old male patient was examined by his family physician during a routine preventive exam. The patient has no specific problems but is HIV positive without any other symptoms.
  – Z00.00 Encounter for general adult medical examination **without abnormal findings**
  – Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
Counseling

Counseling Z codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems.

They are not necessary for use in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.
- Z30.0 - Encounter for general counseling and advice on contraception
- Z31.5 - Encounter for genetic counseling
- Z31.6 - Encounter for general counseling and advice on procreation
- Z32.2 - Encounter for childbirth instruction
- Z32.3 - Encounter for childcare instruction
- Z69 - Encounter for mental health services for victim and perpetrator of abuse
- Z70 - Counseling related to sexual attitude, behavior and orientation
- Z71 - Persons encountering health services for other counseling and medical advice, not elsewhere
Screening

• Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (eg, screening mammogram).

• The testing of a person to rule out or confirm a suspected diagnosis because the patient has some *sign or symptom* is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.
Annual Physical

• EXAMPLE:
A 35-year-old healthy female went to her internist for an annual physical exam. The patient had no complaints. The physician counseled the patient on diet and exercise and diagnosed the patient as a healthy female with no significant findings.

– Z00.00 Encounter for general adult medical examination without abnormal findings
History (of)

- There are two types of history Z codes, personal and family.
  - Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and may require continued monitoring. Voice memo 7/16/13 Part 1
  - Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.
Personal History

• A patient with a history of breast cancer who is currently using Tamoxifen as a preventive measure visits her oncologist one year after a mastectomy of her left breast due to a malignant tumor which was primary. She is doing well with no sign of recurrence. The physician decided to continue the Tamoxifen therapy and will see her back in follow-up in six months.
  – Z85.3 Personal history of primary malignant neoplasm of the breast
## ICD-10 Examples for Pediatrics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>477.2</td>
<td><strong>ALLERG RHINITIS-CAT/DOG</strong> Allergic rhinitis due to animal (cat) (dog) hair and dander</td>
</tr>
<tr>
<td>J30.81</td>
<td>Other allergic rhinitis Perennial allergic rhinitis (year round allergens: dust, food, dander)</td>
</tr>
<tr>
<td>J30.89</td>
<td>Allergic rhinitis, unspecified</td>
</tr>
<tr>
<td>J30.9</td>
<td></td>
</tr>
<tr>
<td>473.9</td>
<td><strong>CHRONIC SINUSITIS NOS</strong> Chronic maxillary sinusitis Use additional code to identify exposure to tobacco smoke (Z77.22, exposure to smoke in the perinatal period (P96.81) history of tobacco smoke Z87.891. See notes for a complete list</td>
</tr>
<tr>
<td>J32.0</td>
<td>Chronic frontal sinusitis</td>
</tr>
<tr>
<td>J32.1</td>
<td>Chronic ethmoidal sinusitis</td>
</tr>
<tr>
<td>J32.2</td>
<td>Chronic sphenoidal sinusitis</td>
</tr>
<tr>
<td>J32.3</td>
<td>Chronic pansinusitis</td>
</tr>
<tr>
<td>J32.4</td>
<td>Sinusitis (chronic) involving more than one sinus but not pansinusitis</td>
</tr>
<tr>
<td>J32.8</td>
<td>Chronic other sinusitis</td>
</tr>
<tr>
<td>J32.9</td>
<td>Chronic sinusitis, unspecified</td>
</tr>
<tr>
<td>J32.9</td>
<td>Sinusitis (chronic) NOS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>780.60</td>
<td>Fever</td>
</tr>
<tr>
<td>R50.81</td>
<td>Fever presenting with conditions classified elsewhere</td>
</tr>
</tbody>
</table>
| R50.9  | Fever, unspecified                                                           | Fever NOS  
Fever of unknown origin [FUO]  
Fever with chills  
Fever with rigors  
Hyperpyrexia NOS  
Persistent fever  
Pyrexia NOS |
| 784.0  | Headache                                                                    | Facial pain NOS  
atypical face pain (G50.1)  
migraine and other headache syndromes (G43-G44)  
trigeminal neuralgia (G50.0) |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J02.8</td>
<td>Acute pharyngitis due to other specified organisms</td>
<td>Use additional code (B95-B97) to identify infectious agent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute pharyngitis due to coxsackie virus (B08.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute pharyngitis due to gonococcus (A54.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute pharyngitis due to herpes [simplex] virus (B00.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute pharyngitis due to infectious mononucleosis (B27.-)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute pharyngitis due to influenza virus (J09.02, J09.12, J10.1, J11.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>enteroviral vesicular pharyngitis (B08.5)</td>
</tr>
<tr>
<td>J02.9</td>
<td>Acute pharyngitis, unspecified</td>
<td>Gangrenous pharyngitis (acute)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infective pharyngitis (acute) NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharyngitis (acute) NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sore throat (acute) NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suppurative pharyngitis (acute)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ulcerative pharyngitis (acute)</td>
</tr>
<tr>
<td>J03.80</td>
<td>Acute tonsillitis due to other specified organisms</td>
<td></td>
</tr>
<tr>
<td>J03.81</td>
<td>Acute recurrent tonsillitis due to other specified organisms</td>
<td></td>
</tr>
<tr>
<td>J03.90</td>
<td>Acute tonsillitis, unspecified</td>
<td></td>
</tr>
<tr>
<td>J03.91</td>
<td>Acute recurrent tonsillitis, unspecified</td>
<td></td>
</tr>
</tbody>
</table>
466.0 - ACUTE BRONCHITIS

<table>
<thead>
<tr>
<th>J20.0</th>
<th>Acute bronchitis due to Mycoplasma pneumoniae</th>
<th>Definition: acute inflammation of main branches of bronchial tree due to infectious or irritant agents; symptoms include cough with a varied production of sputum, fever, substernal soreness and lung rales.</th>
</tr>
</thead>
<tbody>
<tr>
<td>J20.1</td>
<td>Acute bronchitis due to Hemophilus influenzae</td>
<td></td>
</tr>
<tr>
<td>J20.2</td>
<td>Acute bronchitis due to streptococcus</td>
<td></td>
</tr>
<tr>
<td>J20.3</td>
<td>Acute bronchitis due to coxsackievirus</td>
<td></td>
</tr>
<tr>
<td>J20.4</td>
<td>Acute bronchitis due to parainfluenza virus</td>
<td></td>
</tr>
<tr>
<td>J20.5</td>
<td>Acute bronchitis due to respiratory syncytial virus</td>
<td></td>
</tr>
<tr>
<td>J20.6</td>
<td>Acute bronchitis due to rhinovirus</td>
<td></td>
</tr>
<tr>
<td>J20.7</td>
<td>Acute bronchitis due to echovirus</td>
<td></td>
</tr>
<tr>
<td>J20.8</td>
<td>Acute bronchitis due to other specified organisms</td>
<td></td>
</tr>
<tr>
<td>J20.9</td>
<td>Acute bronchitis, unspecified</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>ICD-10-CM Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>784.0</td>
<td>G44.1</td>
<td>Vascular headache, not elsewhere classified</td>
</tr>
<tr>
<td>780.79</td>
<td>G93.3</td>
<td>Post viral fatigue syndrome</td>
</tr>
<tr>
<td>787.91</td>
<td>K52.2</td>
<td>Allergic and dietetic gastroenteritis and colitis</td>
</tr>
<tr>
<td></td>
<td>K52.89</td>
<td>Other specified noninfective gastroenteritis and colitis</td>
</tr>
<tr>
<td>786.2</td>
<td>R05</td>
<td>Cough</td>
</tr>
</tbody>
</table>
Physicians Get Ready!

• Become familiar with the new details ICD-10-CM will require in your notes
• Review crosswalks of your most frequently used ICD-9 codes
• There will be a “One to Many” crosswalk- don’t depend on a simple encounter form
• Many Denials and Delays can be avoided with training and good documentation!
CHMB Resources

Education
• ICD-10 Education Now Available at http://www.chmbinc.com/products-page/
• 3 tracks: Physician, Coder and Office Manager
• Discounted pricing available until March 1, 2014
• Courses are valid for 1 year period

Recent White Papers
• ICD-10 Call to Action
• The National Focus on Healthcare Reform
Visit www.chmbinc.com to download
# CHMB Webinar Lineup

## Upcoming Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td>Capturing missing revenue opportunities for Orthopedics</td>
</tr>
</tbody>
</table>
| Wednesday March 5, 2014 | Top 5 Tips to Increase Physician Revenue in 2014  
  *Co-hosted by Ingenious Med* |
| TBD                 | Capturing missing revenue opportunities for Cardiology and Cardiovascular Surgery |

For more information visit [www.chmbinc.com](http://www.chmbinc.com)
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