CHCANYS Presents
Coding for Clinicians
in 2011

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Brown Consulting Associates, Inc.
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Today’s Topics
- FQHCs – A Leader in Health Care
- ICD-9-CM Diagnosis Coding
  - Guidelines
  - Codes
  - ICD-10-CM
- CPT Coding
  - Defining Coding Problems
  - Defining Coding Solutions
  - A ‘Recipe’ for Compliant E/M Coding
  - Wellness/Illness Coding
  - E/M and Surgery – Same Date
Shawn R. Hafer, CCS-P, CPC, Senior consultant and co-owner of Brown Consulting with more than 20 years of physician coding and reimbursement experience in a variety of specialties. She holds coding certifications from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) and is a member of both organizations. Her background provides an excellent foundation for the demanding medical coding environment.

Shawn has been with Brown Consulting for 12 years and served as a coding instructor at the College of Southern Idaho and for Northwest Regional Primary Care Association. Shawn has been a long term member of the Advisory Committee for Coding Education at the College of Southern Idaho. Shawn authors and presents coding seminars and webinars for our many workshop/seminar partners including the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, West Virginia Primary Care Association, Northwest Regional Primary Care Association and many other regional and national groups.

She is uniquely qualified due to her diverse management skills and experience, as well as her coding and billing expertise. Shawn also serves as a senior auditor conducting hundreds of medical record audits each year providing both clinician and coder training in all facets of coding and documentation. She has been involved in small rural health clinic projects served by visiting providers to large inner-city clinics with more than 100 providers. Shawn has worked with healthcare defense attorneys on behalf of physicians involved in third party payer audits. Shawn attended the College of Southern Idaho in Twin Falls, ID and Pima College in Tucson, AZ.

Bonnie R. Lewis, RN, CCS-P, is a private practice reimbursement consultant who has served as a national physician office consultant and seminar speaker for a variety of firms, including St. Anthony Publishing and Consulting in Alexandria, Virginia and Medical Learning Inc. in Minneapolis, Minnesota. Bonnie currently presents approximately 30 seminars each year with the Idaho Medical Association, Montana Medical Association, Iowa Medical Society and other groups. She continues to present seminars and workshops for the Northwest Regional Primary Care Association, Center for Health Training and other groups. Brown Consulting Associates, Inc. has developed and presents live, web-based certification training for the Northwest Regional Primary Care Association. As an instructor at the College of Southern Idaho, Bonnie teaches a three-semester course for students aspiring to become certified coders. During years 2005-2007 Bonnie served on the AHIMA national Physician Practice Council Group. Bonnie has worked with health care legal defense attorneys to assist physicians in resolving third party payer coding actions.

Sixteen years of clinical experience combined with seventeen years of coding consulting and training provides an exceptional skill base for application to the challenging and changing medical coding environment. Bonnie graduated from Los Angeles County-USC Medical Center School of Nursing in 1973. Her nursing experience includes 16 years of office nursing and hospital nursing in the areas of surgery, ER, ICU and home health. She served as an Air Force Flight Nurse.

Bonnie worked in physician office nursing and management, dealing directly with reimbursement issues in Las Vegas, Nevada; Salt Lake City, Utah; and Twin Falls, Idaho. She has been teaching and consulting since 1989 and has worked in 41 states. As a physician reimbursement consultant, Bonnie visits physician offices, clinics and ERs to assess the issues that directly and indirectly affect reimbursement and CMS compliance.

Donna Monroe, CCS-P, CPC, BA, is a senior auditor for BCA, conducting hundreds of record audits each year and providing both clinician and coder training in all facets of coding and documentation. She is the Academic Director of our 23-week Comprehensive Coding Education Program designed for coders aspiring to certification. Donna authors and presents multiple BCA seminars and webinars, drawing from her diverse coding background which includes coding administration and education for a 200-physician, 20-specialty Arizona trauma program, coding education for a multi-state neonatology group, management of a pulmonology physician practice and
Donna served as Communications Director and Reimbursement Specialist for the Idaho Medical Association for five years, interfacing with physicians and medical office staffs to resolve reimbursement and compliance issues. She has expertise working directly with payers on behalf of physicians and with the American Medical Association and national specialty societies. She has developed educational programs on topics ranging from ICD-9-CM and CPT coding to reimbursement issues such as Medicare guidelines and payment methodology. Her current efforts include planning education for physician transition to use of ICD-10-CM for diagnosis coding.

Donna is a graduate of Tulane University (New Orleans) and certified by the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC). She participates in the Minnesota Health Information Management Association (MIHIMA) and the Minneapolis Chapter of AAPC. As a recent breast cancer survivor, Donna’s “seize the day” enthusiasm encompasses her BCA work and her family, including husband Gary, daughter Kate, future son-in-law Drew, and beloved black cat Toby. She resides in the Minneapolis suburb of Victoria, MN.

Dana Fox, CCS-P, CPC, began her Brown Consulting affiliation in June 2007, having completed the BCA coding curriculum at the College of Southern Idaho in Twin Falls. She entered the coding profession five years ago after working on the payer side of the healthcare system for 12 years. She began her career in the Seattle area working as an HMO hospital claims specialist with responsibilities including claims adjudication and research, utilization review, and benefits administration. She then transitioned to a position administering employer-sponsored medical, dental and vision benefits for a third party payer. In subsequent roles she has adjudicated claims for managed care plans, was a customer service representative for a major private insurer, and has provided claims re-pricing, hospital DRG, and claims system monitoring services.

Dana holds certifications and membership from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC). Her education in addition to the CSI credentials includes completion of technical courses encompassing computer and health insurance training and studies in medical terminology and anatomy.

Our Commitment
Brown Consulting Associates, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, Medicare, the Peer Review Organization, private insurance carriers and hospitals. In addition to serving physician offices, Brown Consulting Associates provides specialized training for various third party payers, Military Treatment Facilities, and Federally Qualified Health Care Centers. Brown Consulting Associates offers physician and staff education designed and customized to enhance operations and federal compliance and allow for appropriate third party payer reimbursement.

Our association with the American Health Information Management Association, American Academy of Professional Coders, Medical Group Management Association well as other groups, helps to keep us current in the field of coding, documentation and reimbursement. Our programs and services are designed to assist physicians and their staff to meet the new demands and challenges of coding, documentation, compliance and reimbursement. Customized in-office services and live web-based programs designed to educate physicians and their staff regarding coding, documentation and billing issues will continue to be our focus.

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We Will Help You Work Smarter ††† Not Harder
The Clinician’s Role

- Identify the reason(s) for your services in ICD-9-CM diagnosis codes.
- Identify the services provided for those diagnoses in CPT service codes.
- Document to prove the above.

Reasons to Code Accurately

- Accurate CPT coding represents the correct value of your work (RVUs).
  - Each code has a weighted value representing the work, malpractice and practice expense; expressed as the RVU.
- Accurate CPT coding allows fair and appropriate reimbursement.
- Accurate diagnosis coding reflects the acuity of your patients.
- Accurate diagnosis coding supports the “medical necessity” for your services.
- State, Federal and Payer Compliance.
- It all starts with correct coding!
Who Else is Interested in Coding?

**Payers**
- Quality of care
- Outcome
- Cost
- Validation of service
- Payments
- Coverage

**State/Fed**
- Health answers
- Access for pts.
- Control of personal health care and information
- Education

**Patients**
- Answers
- Control of personal health care and information
- Education

The Great (Coding) Delusion …

“It doesn’t matter what I code; I get paid the same.”

No
Who is responsible for correct coding?

The Clinician
The Coder/Biller
The Clinic Administration

What is the clinicians role?

- Identify the reasons for your services in ICD-9-CM diagnosis codes.
- Identify the services provided for those diagnoses in CPT service codes.
- Document to prove the above.

What is the coders role?

Be sure the codes submitted are correct!
FQHC
THE FEDERALLY QUALIFIED HEALTH CENTER
A VERY SPECIAL PLACE

Clinic Make-Up

Your clinic may serve:

- Medicare/Medicaid patients whose services qualify for reimbursement under FQHC methodology
- Patients who have a form of third-party payer reimbursement
- Patients without any time of insurance/coverage
- Only a specified patient population (tribal)
FQHC Medicare Payments

All-inclusive rate - The “VISIT”

Payments from the Medicare program are made based on an all-inclusive rate per covered visit.

A visit is defined as a face-to-face encounter between a patient and “core clinician” (MD, DO, NP, PA, CNM, CP, CSW) during which an FQHC service is rendered.

- Medically necessary
- Covered service
- Qualifying core clinician
- One visit per day, unless;
  - Two separate visits for different reasons or
  - When one visit is medical and the other w/ CP or Social Worker

Medicare FQHC

Revenue - Self-pay and sliding fee discounts

Copayments and deductibles may be reduced or waived entirely depending upon family income and family size. A patient may be eligible for the sliding scale with a family income of less than 200% (2X) the poverty level.

- Clinic must have written collection policies.
- In some cases clinics may develop a family cap.
- Obtain and re-validate income documentation.
FQHC Collections

- The FQHC must make a genuine attempt to collect.
- Collection policies should be documented.
- Collection efforts should be universal, regardless of payer type.
- Patients should be clearly but professionally educated regarding their obligations.
- Written payment agreements may be helpful.

FQHC Covered Preventive Services

*Not for the sick and injured (screening)*

- Medical social services
- Nutritional assessments and referrals
- Preventive health education
- Well Child Checkups
- Children’s eye/ear exams
- Prenatal and post-partum services
- Family planning services
- Hx/Exam targeted to risk
- Visual acuity/hearing screens
- Cholesterol screening
- Stool for occult blood screen
- Dipstick UA
- Risk assessments and initial counseling re: risk
- Breast, mammogram referral
- Thyroid function (women) screening
- Diabetic Self Training
Special Encounters

- Skilled nursing – is an encounter when pt is in a covered Part A stay.
- Smoking cessation - is an encounter when provided by a core clinician.
- DM education by a registered dietician or nutritional professional may be an encounter
- Surgical aftercare may be an encounter
  - FQHC vs. private payer

FQHC Medicare Payments

*Non-covered FQHC services covered elsewhere*

- If service is covered under a separate Medicare benefit category, bill that category:
  - Labs done by you – bill Part B.
  - EKGs done by you – bill Part B, **but** bill only for the technical component, e.g., 93005 not 93000.
  - X-ray – bill Part B (TC – bill only for the technical component; e.g. 73090-TC).

Not automatically true for Medicaid.
International Classification of Diseases
Diagnosis Coding for Physicians

- Identify the Reason for the Encounter
- Prove Medical Necessity for Service
- Prove Acuity of Patient
- Prove a “Payable Service”

What does your patient look like?
Diagnosis Reporting ‘Rules’

- Code the main reason for the encounter (determined by you) as the first-listed diagnosis.
  - May not be the most significant diagnosis.
    - *Patient with prostate cancer evaluated for bronchitis – bronchitis is first-listed dx TODAY.*
- Code reasons for all studies.
- Code specificity rather than generality.
  - Acute vs. chronic, controlled vs. uncontrolled.
- Code all conditions that affect/require care.
- Do not report unconfirmed diagnoses on the encounter form.

Example: Diagnosis Coding Accuracy 44%-72%

**Diagnosis Error Key:**

1.1 Dx reported for billing is not supported by medical record documentation.
1.2 Dx documented in record is not reported for billing.
1.3 Dx reported for billing is documented in record as unconfirmed.
1.4 Dx reported as #1 for billing does not match primary reason for service per record.
1.5 Dx on EF lacks specificity.
1.6 Dx other error, auditor specify in Comments.
Diagnosis Coding Accuracy: Example From 2010 BCA Initial Audits of Clinics

<table>
<thead>
<tr>
<th>Error %</th>
<th>Error Code</th>
<th>Error Description</th>
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</thead>
<tbody>
<tr>
<td>39%</td>
<td>1.2</td>
<td>Dx in record not reported for billing</td>
</tr>
<tr>
<td>26%</td>
<td>1.1</td>
<td>Dx reported for billing not documented</td>
</tr>
<tr>
<td>26%</td>
<td>1.4</td>
<td>Dx reported as #1 does not match record</td>
</tr>
<tr>
<td>9%</td>
<td>1.5</td>
<td>Dx reported for billing lacks specificity</td>
</tr>
<tr>
<td>0%</td>
<td>1.3</td>
<td>Dx reported for billing is documented unconfirmed</td>
</tr>
</tbody>
</table>

Sample Dx Coding Issues
- V70.0 (Wellness exam) Only mention is that patient needs to schedule an exam.
- DM with complications (documented in record) reported as DM uncomplicated.
- Type 2 Diabetic on insulin – V58.67 Insulin (long-term, current use) was not assigned.
- Hypertensive heart disease coded as hypertension.
- Multiple conditions evaluated, but only one reported for billing.
Sample Dx Coding Issues

- Back pain coded but was encounter for opiate management.
- Late effects of CVA (18 months ago) coded as an acute CVA.
- Asthmatic with exacerbation coded, documentation supports time spent discussing smoking cessation but smoking (tobacco abuse) not reported.

Coding Diabetes

- 250.00 is the default for coding purposes
  - Type II or unspecified type
  - Not stated as uncontrolled
    - Includes “poorly controlled”
    - Without mention of complication
- Document and report for coding:
  - Type I vs. Type II
  - Uncontrolled vs. Controlled
  - Complications/manifestations
  - Insulin use in Type II diabetics
    - Assign V58.67 when a Type II diabetic routinely uses insulin.
Coding DM-Associated Conditions

- Coding diabetic manifestations requires two codes:
  - Sequence first the category 250 code.
    - 250.4x Diabetes with renal manifestations
    - 250.5x Diabetes with ophthalmic manifestations
    - 250.6x Diabetes with neurological manifestations
    - 250.7x Diabetes with peripheral circulatory disorders
    - 250.8x Diabetes with other specified manifestations
  - Code the associated condition second.
    - “Use additional code to identify manifestation”
  - Repeat as needed.

Multiple DM Complications

- Diabetic nephropathy (type II DM controlled)
  - 250.40 DM w/renal manifestations, DM controlled.
  - 583.81 Nephropathy
  - 250.60 DM w/neurologic manifestations
  - 357.2 Polyneuropathy
  - V58.67 Long term insulin
Hypertension: 4 Categories

- 401 Essential Hypertension
  - 401.0 Malignant HTN
  - 401.1 Benign HTN
  - 401.9 Unspecified HTN (most reported HTN code)
- 402 Hypertensive Heart Disease
  - Malignant vs. Benign
  - With or without heart failure
- 403 Hypertensive Chronic Kidney Disease
  - Malignant vs. Benign
  - Identify stage of CKD
- 404 Hypertensive Heart & CKD
  - Malignant vs. Benign
  - With/without heart failure
  - Identify stage of CKD

Incidental finding of elevated blood pressure codes to 796.2.

Hypertensive Heart/Renal Disease

Use additional code to identify the stage of chronic kidney disease:
- 586.1 Chronic kidney disease, Stage I
- 586.2 Chronic kidney disease, Stage II (mild)
- 586.3 Chronic kidney disease, Stage III (mod)
- 586.4 Chronic kidney disease, Stage IV (severe)
- 586.5 Chronic kidney disease, Stage V
- 586.6 End stage renal disease (oncological emergencies)
- 586.9 Chronic kidney disease, unspecified
  - Chronic renal disease
  - Chronic renal failure NOS
  - Chronic renal insufficiency
Pain Management

- Pain diagnoses (examples):
  - 338.0 Central pain syndrome
  - 338.12 Acute post-thoracotomy pain
  - 338.18 Other acute postoperative pain
  - 338.28 Other chronic postoperative pain
  - 338.29 Other chronic pain
  - 338.3 Neoplasm related pain
  - 338.4 Chronic pain syndrome (chronic pain associated with significant psychosocial dysfunction).
- Code also long-term, current drug use V58.61 - V58.69.
  - High risk pain meds, use V58.69.

May be the first-listed code when:
- Pain control/management is the reason for the encounter.
- The definitive diagnosis has not yet been confirmed.
- Reported with other codes to provide more detail about acute or chronic pain and neoplasm-related pain.
  - Example: Pt presents for pain management of chronic low back pain. Hx and exam documented…pain meds refilled.
    1. 338.29 Other chronic pain
    2. 724.2 Low back pain
    3. V58.69 Current, long-term use of other high-risk medication, methadone, opiates…
Medication Management

- #1. V58.83 Encounter for therapeutic drug monitoring
  - Assigned when a patient’s medication is being monitored.
  - Additional code is used for long term medication use (V58.61-V58.69). Some examples include:
    - Lithium
    - Coumadin
    - Dilantin
    - Pain medication
- #2. Also report underlying condition(s), e.g. A-fib, 427.31

Wellness Diagnosis Coding

- V20.2 Routine infant/child health check
- V20.3 Newborn health supervision (weight, feeding...)
  - V20.31 Health check for newborn under 8 days of age.
  - V20.32 Health check for newborn 8-28 days of age.
- V70.0 Routine general medical examination.
- V72.31 Routine GYN exam with or w/o cervical Pap screening.
Wellness Diagnosis Coding

- Use additional screening codes when appropriate (V73.0-V82.9):
  - Screening cervical Pap smear, V76.2.
    - Don’t report with V72.31; already included in description.
  - HPV screening, V73.81
  - Cholesterol screening, V77.91
- Use additional code(s) for immunizations given.

Screening vs. Diagnostic

- Special screening exam codes (V73–V82) are assigned for services directed at early detection for patients who do not present with signs, symptoms, or diagnoses.
  - Diabetes mellitus V77.1
    - Also code Family History of DM, V18.0, when appropriate.
  - Cholesterol level V77.91
    - Also code Family History, V17.4, when appropriate.
  - Thyroid disorders V77.0
    - Also code Family History, V18.1, when appropriate.
- Testing of an individual to confirm or rule out a suspected diagnosis because of signs or symptoms is a diagnostic exam, not a screening.
  - Report the sign or symptom as the reason for the test.
Wellness Diagnosis Coding

• A Well Woman Exam with a screening cervical Pap should be coded as:
  1. V70.0 General medical exam
  2. V76.2 Screening cervical Pap smear

• State specific programs may vary their instructions; e.g. require V72.31. If so, follow those instructions.

Wellness Diagnosis Coding

• Well Woman with vaginal Pap smear s/p hysterectomy for non-malignant condition:
  1. V70.0 General medical exam
  2. V76.47 Vaginal Pap smear
  3. V88.01 Acquired absence of both cervix and uterus.
     • V88.02 Acquired absence of uterus with remaining cervical stump; s/p partial hysterectomy.
     • V88.03 Acquired absence of cervix with remaining uterus.
Wellness Diagnosis Coding

- Well Woman with vaginal Pap smear s/p hysterectomy for malignant condition:
  1. V70.0 General medical exam
  2. V67.01 Vaginal Pap smear
  3. V88.01 Acquired absence of both cervix and uterus.
     - V88.02 Acquired absence of uterus with remaining cervical stump; s/p partial hysterectomy.
     - V88.03 Acquired absence of cervix with remaining uterus.
  4. Personal history of malignant neoplasm, V10.40-V10.44

Prenatal Visits
(Reference Chapter 11 Guidelines)

Essentially three categories for code selection:

1. Normal Pregnancy (V22.0-V22.2)
2. High Risk Pregnancy (V23.0-V23.9)
3. Antepartum Conditions (640-649, 651-676)
Normal Pregnancy

- V22.0 Supervision of normal first pregnancy.
- V22.1 Supervision of other normal pregnancy.
  - For routine outpatient prenatal visits when no complications (630-679) or risk factors (V23) exist.
  - Do not report with a code from the OB Section, Chapter 11.
- V22.2 Pregnant state, incidental
  - The condition for which the patient is seen today is not affecting or related to the pregnancy.
    - Clinician must document this statement in order to code.
  - Reported in addition to the code for today’s condition.
  - Reported instead of Chapter 11 codes (630-679)

High Risk Pregnancy

- A patient may be considered to have a high risk pregnancy because she:
  - Had a problem in a previous pregnancy (Hx of PTL).
  - Has had a condition that may complicate her current pregnancy.
  - Has other factors that increase her risk of problems in the current pregnancy.
- Examples:
  - V23.41 Pregnant w/hx of pre-term labor
  - V23.7 Insufficient prenatal care
  - V23.82 Elderly multigravida (>34 yrs @ delivery)
- Do not report with a V22 code.
- May report with other Chapter 11 codes (630-679).
Antepartum Conditions

- Don’t code as “normal” pregnancy when conditions are present that affect pregnancy/management;
  - 642.43 Pregnant w/toxemia, mild
  - 648.83 Pregnant w/diabetes mellitus
  - 648.43 Pregnant w/mental disorder
  - 649.13 Obesity complicating pregnancy
- Also code specific condition when appropriate (648 category):
  1. Pregnant Type 2 Diabetic, 648.03
  2. Type 2 DM, controlled, 250.00

Diagnosis Coding Review

- The main reason for the service(s) is coded first.
  - May not be the most significant diagnosis.
- If the diagnosis has not been established, code signs, symptoms or abnormal test results that you can confirm today.
- Code all conditions that affect or require care, treatment, or management.
  - Includes reasons for labs, x-rays, etc.
- ICD-9 codes are updated every April and October 1st.
New 2011 ICD-9 Codes

New Codes Were Effective October 1, 2010

Can this be done on one slide? Codes may not be on Favorites??

ICD-9-CM Update 2011

- Changes effective October 1, 2010.
- Minimal changes compared to previous years.
  - ICD-9-CM increasingly unable to accommodate expansion.
  - Anticipated implementation of ICD-10-CM in 2013.
- Complete lists of 2011 New, Revised and Invalid codes in your handout:
  - New = 130 (compare to 313 new codes for 2010)
    - 55 new V codes
  - Revised = 16
  - Invalid = 13
- Most recent “official guidelines” effective 10-1-10.
  - Published August 5, 2010 – see NCHS website.
  - Note effective date of guidelines in your 2011 book.
ICD-9-CM Changes for 2011

- Transfusion complications, incompatibility reactions
- Fluency disorders, stuttering
- Avian, H1N1 Influenza
- Female congenital anomalies
- Corrected congenital anomalies
- Multiple pregnancies
- Cognitive deficits
- Extreme obesity

ICD-10-CM for 2013

An Introduction
ICD-10-CM

  - Transition driven by date of service for physician reporting and in ambulatory settings.
  - Date of discharge for inpatient settings.
- Website for ICD-10-CM information and codes
  - www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm
- Ponder the scope:
  - ICD-9-CM 14,025 codes
  - ICD-10-CM 69,099 codes (not including PCS codes)
- Get started now: vendors, impact analysis, budget.

What we know about ICD-10-CM

- The International Classification of Disease (ICD)
  - Was created for mortality reporting.
  - Is expanded with “CM,” (clinical modification) in the United States: ICD-9-CM and ICD-10-CM.
  - Operates on a hierarchical rubric system, so that all codes that begin with the same “rubric,” three-digit category, are all part of the same disease system.
- Final implementation date is October 1, 2013.
- Involves many “players”:
  - World Health Organization
  - National Center for Health Statistics
  - Centers for Medicare and Medicaid Services
Preparing for ICD-10

- Features of the code set:
  - More complete than ICD-9-CM, greater specificity.
  - Easy to expand the system.
  - Multi-axial structure makes it easier to analyze.
  - Standardized terminology makes it easier to use once the coder has initial training.
  - Initial training time will be a factor since ICD-10-CM differs significantly from ICD-9-CM:
    - Having all terms defined makes it easier to teach.

Philosophy of ICD-10-CM

- Good information is at the heart of good health care.
  - The data generated by ICD-10 will put accurate, concise patient data at fingertips of caregivers.
- Quality equals cost-effectiveness.
  - “The right treatment at the right time.”
- Preventable errors reduction:
  - Medical errors.
  - Medication errors.
- National system to identify healthcare issues:
  - Epidemics at an early stage.
  - Patterns of adverse drug reactions.
Structure of ICD-9 vs ICD-10

- **ICD-9**
  - 3-5 characters
  - First character is numeric or alpha (E or V)
  - Characters 2-5 are numeric
  - Always at least 3 characters
  - Use of decimal after 3 characters
  - Alpha characters are not case-sensitive

- **ICD-10**
  - 3-7 characters
  - Character 1 is alpha
  - Character 2 is numeric
  - Characters 3-7 are alpha or numeric
  - All letters except U are used
  - Always at least 3 characters
  - Use of decimal after 3 characters
  - Alpha characters are not case-sensitive

Similarities and Differences

- Much of what you see in ICD-10-CM will be familiar:
  - Rubric system
  - Index conventions
  - Tabular conventions
  - Includes notes
  - Inclusion terms
  - Neoplasm table

- Some areas will be significantly changed compared to ICD-9-CM:
  - Injuries
  - Combined codes
  - Reassignment of existing codes to new categories
  - Alpha extensions
  - Excludes note changes
  - Some changes to guidelines
ICD-10-CM Structure:
3 to 6 position code with leading alpha (+ extension)

Alpha extensions: Injuries

- Always the 7th (last) digit:
  - a initial encounter for closed fracture
  - b initial encounter for open fracture
  - d subsequent encounter fracture with routine healing
  - g subsequent encounter fracture with delayed healing
  - k subsequent encounter for fracture with nonunion
  - p subsequent encounter for fracture with malunion
  - s sequela
- Example S62.524d Nondisplaced fracture of distal phalanx of right thumb, subsequent encounter for fracture with routine healing
Combined codes: Diabetes

- Diagnosis: Type II diabetes mellitus with nephropathy
  - ICD-9-CM two codes: 250.40 + 581.81
  - ICD-10-CM one code E08.21 (both DM and complication are combined into a single code).
- Other examples of combined codes under Diabetes:
  - E08.43 Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
  - E09.00 Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
  - E10.52 Type I diabetes mellitus with diabetic peripheral angiopathy with gangrene
  - E11.319 Type II diabetes mellitus with diabetic unspecified diabetic retinopathy without macular edema
  - E13.620 Other specified diabetes mellitus with diabetic dermatitis.
- DM no longer coded "controlled" vs "uncontrolled."

Evaluate the impact on each stakeholder

<table>
<thead>
<tr>
<th>Clinician Benefits</th>
<th>Clinician Risks</th>
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<tbody>
<tr>
<td>Better profiling due to the specificity of data collected</td>
<td>Medical terminology challenges in documentation</td>
</tr>
<tr>
<td>Improved clinical information for research</td>
<td>Increased documentation requirements</td>
</tr>
<tr>
<td>Clearer code choices</td>
<td>Increased queries for coding clarification</td>
</tr>
<tr>
<td>Clearer reimbursement guidelines</td>
<td>Reimbursement delays</td>
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Brown Consulting Associates, Inc. 2010
ICD-10-CM Clinical Preparedness

Avoid the potential of on slot of denials/payment delays

1. Take an active leadership role
2. Test process and system as soon as testing available
3. Improve level of ICD-9-CM coding competence
   - 2010–early 2011 - Assess your accuracy of current diagnosis coding
   - Internal audits of coder and clinicians
4. Train clinicians
   - 2011 - Improve competence in ICD-9-CM diagnosis coding guidelines and code assignments
   - 2010 - Provide paper/electronic diagnosis training tools

ICD-10-CM Clinical Preparedness

Avoid the potential of on slot of denials/payment delays

5. Train coders
   - 2010 and forward - Empower coders to train clinicians.
   - 2010-2011 - Evaluate coder current coding base of knowledge related to both ICD-9-CM coding guidelines and coding.
   - 2011 and forward “Scrub” claims before submission.
   - 2011 – Provide course study in Medical Terminology
   - 2011 – 2012 - course study in Disease Process, then consider Anatomy/Physiology & Pharmacology
   - 2011 – 2012 – Guide coder(s) toward obtaining certification
   - Jan–Sept 2013 - Coders should have ICD-9 & ICD-10 code books and be given time to review/code some claims from both.
E/M Visit Coding

Evaluation and Management (E/M) Level of Service

Evaluation/Management Services

- CPT Evaluation and Management (E/M) Services (99201-99499):
  - Known as “encounter” or “visit” codes.
  - Provided at many sites of service.
  - CPT Guidelines apply.
    - Many Categories and Subcategories, differing criteria
  - CMS Guidelines apply.
E/M Production

XXXXX Clinic Production
4743 Established Patient Encounters

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>99212</td>
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<tr>
<td>99213</td>
<td>63%</td>
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<tr>
<td>99214</td>
<td>9%</td>
</tr>
<tr>
<td>99215</td>
<td>0%</td>
</tr>
</tbody>
</table>

Example: Collective E/M Audit Results

Audit Results
100 Records - 10 Clinicians

- Correct: 66%
- Undercoded: 12%
- Underdoc: 6%
- Overcoded: 16%
- Miscoded: 1%
- Dx Accuracy: 76%
Audit Results

- **Undercoding**: Documentation and patient complexity support a higher code than was selected.
- **Underdocumenting**: Selected code is appropriate based on MDM complexity, but documentation lacks required Hx and/or Exam.
- **Overcoding**: Documented MDM does not support the assigned code and there is not clear medical necessity to assign code based on history and exam.
- **Miscoding**: Incorrect code type selected; eg, new vs. established, wellness vs. illness.

---

The Problem with E/M Coding

- *Most physicians have a hard time being compliant with the E/M guidelines because they don’t have a concrete plan to apply them in daily practice.* In the current climate of increasing regulatory scrutiny, it is reckless and naïve to cobble together your documentation, circle an E/M code and simply hope for the best. Now, more than ever, forces are gathering to squash physicians who demonstrate a casual attitude toward E/M compliance.

--- Peter R. Jensen, MD, CPC
How to Select Your E/M Code
First Considerations

- Is the patient new or established?
- Is the patient here to confirm wellness (preventive) or is the patient here for management of illness? Or both?

Compare Requirements!

**99203**
- 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:
  - Detailed history;
  - Detailed examination; and
  - Low complexity medical decision making.
- … Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient …

**99213**
- 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
  - Expanded problem focused history;
  - Expanded problem focused exam;
  - Low complexity medical decision making.
- … Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient …
Make an E/M Plan!

- E/M code selection depends on your documentation.
- Codes may be selected in one of two ways:
  1. Key Component Coding:
     - History
     - Examination
     - Medical Decision Making
  2. Counseling and/or Coordination of Care Time
     (alternate technique).

Time Based Coding

The “Greater Than 50%” Rule

When more than 50% of the face-to-face encounter is devoted to counseling or coordination of care, you may default to the documented time to assign the E/M code.
Time Based E/M Coding

- The “Greater Than 50 Percent” Rule
  - Use when today’s encounter is not conducive to coding based on key components.
  - Clinician’s face-to-face time with the patient in the office or outpatient setting.
  - For use with E/M codes that include a time component.
  - Don’t abuse this technique; may appear suspect to an outside auditor.

Time Based E/M Coding

- Counseling is a discussion with a patient and/or family concerning one or more of the following topics:
  - Diagnostic results, impressions, recommended studies
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reduction
  - Patient and family education
Time Based E/M Coding

- Documentation must include three distinct elements:
  1. Total encounter time in minutes
  2. Time devoted to counseling/coordination of care (confirm it was more than half)
  3. Content of the encounter

- Example for 99214:
  - "15/25 minutes spent reviewing and discussing test results with the patient, discussing the risks and benefits of treatment, importance of compliance with treatment plan..."

99214 Based on Time

- CC: Patient returns today with studies completed. The **entire 25 minute** encounter was spent counseling patient on various treatment options and plans.
- Assessment: New Type II DM
- Plan: Diet, exercise, glucose monitoring, return in one month with diary.
  - “...The majority of the 25 minute visit...”
  - “... 15/25 minutes...”
99214 Based on Time

- CC: Follow-up daily headaches and BP
- HPI: Pt. followed for HTN since 2008 and has been resistant to taking meds. She thinks headaches are related to HTN, getting worse.
- **15 of 25 minutes** spent counseling regarding disease process, treatment plan, importance of compliance with chosen plan…

A: Uncontrolled HTN, noncompliance
P: Meds, diet, exercise, and lytes. Return 10 days.

Use of Time in E/M Coding

- **CC:** Client has vaginal itching and headaches she contributes to her method….multiple partners…
- **Exam:** none
- **15 of 25 minute visit** spent counseling regarding safety and efficacy of current method & multiple partners/no condoms.

**Assessment:**
1. Contraceptive Management with contraceptive vaginal ring.
2. High risk sexual behavior

**Plan:** Continue method, return as scheduled.
The Three Key Components

1. History
2. Exam
3. Medical Decision Making

A Solution for Compliant E/M Coding

<table>
<thead>
<tr>
<th>2010 Brown Consulting - E/M Recipe Card</th>
<th>Use the back first</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient MDM</strong></td>
<td></td>
</tr>
<tr>
<td>All 3</td>
<td>HISTORY O.R. EXAM</td>
</tr>
<tr>
<td>Straightforward MDM</td>
<td></td>
</tr>
<tr>
<td>CC, H&amp;P, 1-2 questions, and R/O, 2.5 systems</td>
<td>2.5 min</td>
</tr>
<tr>
<td>Moderate Complexity MDM</td>
<td></td>
</tr>
<tr>
<td>CC, H&amp;P, 2-3 questions, and 3 systems</td>
<td>5 min</td>
</tr>
<tr>
<td>High Complexity MDM</td>
<td></td>
</tr>
<tr>
<td>CC, H&amp;P, 3-4 questions, and 4 systems</td>
<td>10 min</td>
</tr>
<tr>
<td>Total Professional (in office)</td>
<td>10 min</td>
</tr>
</tbody>
</table>

**35 min**

Brown Consulting Associates, Inc. 2010
Component Coding
History & Exam (Key Components 1 & 2)

HISTORY
- Chief complaint
- HPI
- ROS
- Past medical history
- Past family history
- Past social history

EXAMINATION
- Exam of one to eight or more body systems. *CMS GL 1995*
- Varied number of exam elements from varied number of body systems. *CMS GL 1997*

Who can Help?
- CC and HPI
  - Only Clinician.
- ROS and Past Hx
  - Nurse or MA
    - With your review and verification.
- Exam
  - VS – Only portion the nurse/MA can do.
  - “Nursing assessment” by qualified nurses may be included if properly identified, but are not “counted” in clinician code.
Key #3 Medical Decision Making

- MDM encompasses the documented work to determine what is wrong with the patient and what treatment is needed.
  - “Thinking” “Brain power”
- Three areas of MDM:
  1. Number of diagnostic and treatment options
  2. Amount and complexity of data reviewed
  3. Patient’s risk for complications, morbidity, and mortality

MDM per CMS

- Each encounter should include an assessment, clinical impression and diagnosis.
- Initiation of, or changes in, treatment should be documented.
- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral/consultation is made or from whom advice is requested.
MDM Recipe

Consider MDM first, then turn over for Hx and/or Ex requirements.

- **Simplified** problem stable or improving, or
- **Minor** problem today

- **Low MDM: 95213** (Nov: 95213)
  - 2 months/4 weeks of a scale uncomplicated illness such as bronchitis, URI, cold, or 1 month worsening not responding to tx.

- **Moderate MDM: 96214** (Nov: 95214)
  - 3 or more chronic stable or unstable problems
  - 1 significant new problem with other problem(s)
  - 1 diagnosis new problem with uncertain outcome
  - History with no treatment, or treatment result documented

- **High MDM: 96215** (Nov: 95215)
  - History with no treatment, or treatment result documented
  - New or significant new problem
  - This tool is intended for clinics use after training.
  

Hx and Ex Recipe

**2010 Brown Consulting - E/M Recipe Card**

<table>
<thead>
<tr>
<th>Established Pt</th>
<th>EXAM</th>
<th>OR</th>
<th>HISTORY</th>
<th>2 of 3</th>
<th>Est. Pt Time GL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward MDM</td>
<td>2 systems</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
<tr>
<td>Low Complexity MDM</td>
<td>2 systems</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
<tr>
<td>High Complexity MDM</td>
<td>2 systems</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
<tr>
<td>Nurse, MA or &quot;very minimal&quot; by clinician</td>
<td>and</td>
<td>documented</td>
<td>2 of 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Patient MDM</th>
<th>EXAM</th>
<th>OR</th>
<th>HISTORY</th>
<th>2 of 3</th>
<th>Est. Pt Time GL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward MDM</td>
<td>1 system</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
<tr>
<td>Low Complexity MDM</td>
<td>2 systems</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
<tr>
<td>Moderate Complex MDM</td>
<td>2 systems</td>
<td>0-3 sys</td>
<td>1-3 sys</td>
<td>2/3</td>
<td>15 min</td>
</tr>
</tbody>
</table>

Brown Consulting Associates, Inc. 2010
E/M Suggestions

- Established patients; focus on 99213, 99214
  - 2 of 3 key components required
  - 99214 hx and exam = 99203 hx and exam
  - Think about your routine
  - If you do less work; code lower

<table>
<thead>
<tr>
<th>E/M Suggestions</th>
<th>2010 Brown Consulting - E/M Recipe Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient MDM</td>
<td>Est Pt Time Gl</td>
</tr>
<tr>
<td>Straightforward MDM</td>
<td>CC &amp; B&amp;H Hx &amp; 1st HPI qualified</td>
</tr>
<tr>
<td>Low Complexity MDM</td>
<td>CC; HPI x1, 2px and ROS x1 system</td>
</tr>
<tr>
<td>Moderate Complexity MDM</td>
<td>CC; HPI x4 qualified, ROS x3 systems</td>
</tr>
<tr>
<td>High Complexity MDM</td>
<td>CC; HPI x4, ROS x4, 2 px</td>
</tr>
</tbody>
</table>

- New patients; focus on 99202, 99203
  - 3 of 3 key components required
  - Think about your routine for new patients.
    - Consider a 99203 routine. If you do less work; code lower.
    - Typically best to avoid 99204 (review recipe).
Focus on Wellness
99381-99397
The patient presents to confirm wellness.
- Annual PAP/Pelvic
- Well Child
- Immigration
- Drivers
- Pilot
- Sports (99499 vs. 993XX-52)

Components of Wellness
- Age and Gender Appropriate:
  - History
  - Exam
  - Counseling
  - Anticipatory Guidance
  - Risk factor reduction
  - Ordering of labs/procedures
- Service does not include management of illness.
Wellness and Illness Same Date

- If illness is evaluated and treated during a preventive service and it's significant enough to require additional work of the key components, report a wellness E/M and an illness E/M.
  - 99392 with V20.2 (well child check)
  - 99212-25 with 466.0 (with acute bronchitis)
    - Modifier 25 must be appended to the illness E/M.

Documentation must support both services.

Code the illness E/M lower than you normally would.

If it's worth an extra code, it's worth an extra paragraph!
Wellness and Illness Same Date

- “An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.”

Wellness Turned Illness

- Wellness visit planned but upon completing history and exam it is clear the encounter will deal with “illness” – The clinician converts this encounter from wellness to illness.
  - Example: 5-year-old scheduled for WCC but comes in with complaints of fever, nausea and vomiting x24 hours…(Provider explains the illness will be treated today and the WCC will be rescheduled until the pt is feeling better.)
Surgery Coding
E/M and Surgery on the Same Date

Code E/M and Surgery

- When you perform both an E/M (history, exam and MDM) and a procedure … and both are documented.
- E/M involves more than the usual pre-op work.
- Best Practice: Write a separate procedure note.
Code Surgery Only

- When you perform only the surgery.
- Every surgery includes “usual pre- and post-op work.”
- When the surgery was previously planned.
- Code surgery only.

---

E/M and Surgery

S: Patient comes in c/o a possible spider bite on the left arm. This occurred two weeks ago and started as a rather small lesion, but has been getting bigger and worsening over time. He denies fever and chills, but c/o increasing pain. He did have what sounds like an initial cellulitis evolving into an abscess and then with spontaneous drainage one day ago.

O: Focal exam of the left elbow reveals a 2cm x 5cm cellulitic lesion with multiple perforations draining purulent and bloody fluid. There is still some fluctuance below. There is no streaking or signs of lymphangitis. Pt is afebrile; VSS per flow sheet.

A: Abscess. Likely MRSA infection of the left elbow.

P: I&D performed using an 11 blade and 2% lidocaine without epinephrine for local anesthesia. Using sterile technique loculations were disrupted with a mosquito pliers and was packed with iodoform gauze. He is to remove the iodoform gauze in 48 hours and to apply bacitracin ointment topically daily along with wound dressing over the next five days. He will return if he experiences fevers, chills or other constitutional symptoms. Rx for Bactrim DS, one tablet PO twice daily for two weeks.
Measuring and Coding Lesions

- 11423 Excision, benign lesion including margins; excised diameter 2.1 to 3.0 cm. (RVU 5.06)
- 11422 excised diameter 1.1 to 2.0 cm. (RVU 4.33)
- “Excised lesion with margins measured 2.4cm”

Coding Accuracy Matters

- Relative Value Unit (RVU) Comparison
  MPFSDB (cms.hhs.gov)

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure (See CPT)</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>12001</td>
<td>Repair 2.5cm, simple</td>
<td>3.85</td>
</tr>
<tr>
<td>12031</td>
<td>Repair 2.5cm, intermediate</td>
<td>6.12</td>
</tr>
<tr>
<td>17000</td>
<td>Destroy skin lesion</td>
<td>2.04</td>
</tr>
<tr>
<td>51056</td>
<td>Destroy penile lesion</td>
<td>3.65</td>
</tr>
<tr>
<td>96372</td>
<td>IM injection</td>
<td>0.59</td>
</tr>
<tr>
<td>20610</td>
<td>Joint inection</td>
<td>1.98</td>
</tr>
</tbody>
</table>

http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4
Golden Rule of Coding/Documentation

Document what you do; code what you document.

Thank you for allowing Brown Consulting Associates to help.

Codingquestions@codinghelp.com
General Training Disclaimer

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- The content of this presentation has been abbreviated for a focused presentation for a specific audience. Verify all codes and information in a current CPT book.
- This information is considered valid at the time of presentation but changes may occur through the year.
- Information presented is not to be considered legal advice.
- Third-party payment guidelines vary. Confirm payment guidelines with your payers of interest.
NEW DIAGNOSIS CODES
Effective October 1, 2010

The final addendum providing complete information on changes to the diagnosis part of ICD-9-CM is posted on CDC’s webpage at: www.cdc.gov/nchs/icd9.htm

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<th>Diagnosis Code</th>
<th>Description</th>
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<td>Schwannomatosis</td>
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<tr>
<td>237.79*</td>
<td>Other neurofibromatosis</td>
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<tr>
<td>275.01</td>
<td>Hereditary hemochromatosis</td>
</tr>
<tr>
<td>275.02</td>
<td>Hemochromatosis due to repeated red blood cell transfusions</td>
</tr>
<tr>
<td>275.03</td>
<td>Other hemochromatosis</td>
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<tr>
<td>275.09</td>
<td>Other disorders of iron metabolism</td>
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<tr>
<td>276.61</td>
<td>Transfusion associated circulatory overload</td>
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<tr>
<td>276.69</td>
<td>Other fluid overload</td>
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<td>278.03</td>
<td>Obesity hypoventilation syndrome</td>
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<td>287.41</td>
<td>Posttransfusion purpura</td>
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<td>287.49</td>
<td>Other secondary thrombocytopenia</td>
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<tr>
<td>315.35*</td>
<td>Childhood onset fluency disorder</td>
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<td>Aortic ectasia, unspecified site</td>
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<td>Thoracic aortic ectasia</td>
</tr>
<tr>
<td>447.72</td>
<td>Abdominal aortic ectasia</td>
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<td>447.73</td>
<td>Thoracoabdominal aortic ectasia</td>
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<td>Influenza due to identified avian influenza virus with pneumonia</td>
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<tr>
<td>488.02*</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
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<tr>
<td>488.09*</td>
<td>Influenza due to identified avian influenza virus with other manifestations</td>
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<td>Influenza due to identified novel H1N1 influenza virus with pneumonia</td>
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<td>Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations</td>
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<tr>
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<td>Fecal impaction</td>
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<td>Agenesis of uterus</td>
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<td>752.32</td>
<td>Hypoplasia of uterus</td>
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<td>752.33</td>
<td>Unicornuate uterus</td>
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<td>752.34</td>
<td>Bicornuate uterus</td>
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<td>Septate uterus</td>
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<td>752.36</td>
<td>Arcuate uterus</td>
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<td>Other anomalies of uterus</td>
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<td>Febrile nonhemolytic transfusion reaction</td>
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<td>Diagnosis Code</td>
<td>Description</td>
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<td>-------------</td>
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<td>784.52*</td>
<td>Fluency disorder in conditions classified elsewhere</td>
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<td>Hemoptysis, unspecified</td>
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<td>Acute idiopathic pulmonary hemorrhage in infants [AIPHI]</td>
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<tr>
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<td>Other hemoptysis</td>
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<td>Full incontinence of feces</td>
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<td>Incomplete defecation</td>
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<td>Fecal smearing</td>
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<tr>
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<td>Fecal urgency</td>
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<td>799.51</td>
<td>Attention or concentration deficit</td>
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<td>Cognitive communication deficit</td>
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<td>799.53</td>
<td>Visuospatial deficit</td>
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<td>Psychomotor deficit</td>
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<td>Frontal lobe and executive function deficit</td>
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<td>799.59</td>
<td>Other signs and symptoms involving cognition</td>
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<td>970.81</td>
<td>Poisoning by cocaine</td>
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<td>970.89</td>
<td>Poisoning by other central nervous system stimulants</td>
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<td>ABO incompatibility reaction, unspecified</td>
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<tr>
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<td>ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed</td>
</tr>
<tr>
<td>999.62</td>
<td>ABO incompatibility with acute hemolytic transfusion reaction</td>
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<tr>
<td>999.63</td>
<td>ABO incompatibility with delayed hemolytic transfusion reaction</td>
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<td>999.69</td>
<td>Other ABO incompatibility reaction</td>
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<td>Rh incompatibility reaction, unspecified</td>
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<tr>
<td>999.78</td>
<td>Non-ABO incompatibility with delayed hemolytic transfusion reaction</td>
</tr>
<tr>
<td>999.79</td>
<td>Other non-ABO incompatibility reaction</td>
</tr>
<tr>
<td>999.80</td>
<td>Transfusion reaction, unspecified</td>
</tr>
<tr>
<td>999.83</td>
<td>Hemolytic transfusion reaction, incompatibility unspecified</td>
</tr>
<tr>
<td>999.84</td>
<td>Acute hemolytic transfusion reaction, incompatibility unspecified</td>
</tr>
<tr>
<td>999.85</td>
<td>Delayed hemolytic transfusion reaction, incompatibility unspecified</td>
</tr>
<tr>
<td>E000.2</td>
<td>Volunteer activity</td>
</tr>
<tr>
<td>V11.4</td>
<td>Personal history of combat and operational stress reaction</td>
</tr>
<tr>
<td>V13.23</td>
<td>Personal history of vaginal dysplasia</td>
</tr>
<tr>
<td>V13.24</td>
<td>Personal history of vulvar dysplasia</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>V13.62</td>
<td>Personal history of other (corrected) congenital malformations of genitourinary system</td>
</tr>
<tr>
<td>V13.63</td>
<td>Personal history of (corrected) congenital malformations of nervous system</td>
</tr>
<tr>
<td>V13.64</td>
<td>Personal history of (corrected) congenital malformations of eye, ear, face and neck</td>
</tr>
<tr>
<td>V13.65</td>
<td>Personal history of (corrected) congenital malformations of heart and circulatory system</td>
</tr>
<tr>
<td>V13.66</td>
<td>Personal history of (corrected) congenital malformations of respiratory system</td>
</tr>
<tr>
<td>V13.67</td>
<td>Personal history of (corrected) congenital malformations of digestive system</td>
</tr>
<tr>
<td>V13.68**</td>
<td>Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal systems</td>
</tr>
<tr>
<td>V15.53</td>
<td>Personal history of retained foreign body fully removed</td>
</tr>
<tr>
<td>V25.11</td>
<td>Encounter for insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.12</td>
<td>Encounter for removal of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.13</td>
<td>Encounter for removal and reinsertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V49.86</td>
<td>Do not resuscitate status</td>
</tr>
<tr>
<td>V49.87*</td>
<td>Physical restraints status</td>
</tr>
<tr>
<td>V62.85</td>
<td>Homicidal ideation</td>
</tr>
<tr>
<td>V85.41</td>
<td>Body Mass Index 40.0-44.9, adult</td>
</tr>
<tr>
<td>V85.42</td>
<td>Body Mass Index 45.0-49.9, adult</td>
</tr>
<tr>
<td>V85.43</td>
<td>Body Mass Index 50.0-59.9, adult</td>
</tr>
<tr>
<td>V85.44</td>
<td>Body Mass Index 60.0-69.9, adult</td>
</tr>
<tr>
<td>V85.45</td>
<td>Body Mass Index 70 and over, adult</td>
</tr>
<tr>
<td>V88.11</td>
<td>Acquired total absence of pancreas</td>
</tr>
<tr>
<td>V88.12</td>
<td>Acquired partial absence of pancreas</td>
</tr>
<tr>
<td>V90.01</td>
<td>Retained depleted uranium fragments</td>
</tr>
<tr>
<td>V90.09</td>
<td>Other retained radioactive fragments</td>
</tr>
<tr>
<td>V90.10</td>
<td>Retained metal fragments, unspecified</td>
</tr>
<tr>
<td>V90.11</td>
<td>Retained magnetic metal fragments</td>
</tr>
<tr>
<td>V90.12</td>
<td>Retained nonmagnetic metal fragments</td>
</tr>
<tr>
<td>V90.2</td>
<td>Retained plastic fragments</td>
</tr>
<tr>
<td>V90.31</td>
<td>Retained animal quills or spines</td>
</tr>
<tr>
<td>V90.32</td>
<td>Retained tooth</td>
</tr>
<tr>
<td>V90.33</td>
<td>Retained wood fragments</td>
</tr>
<tr>
<td>V90.39</td>
<td>Other retained organic fragments</td>
</tr>
<tr>
<td>V90.81</td>
<td>Retained glass fragments</td>
</tr>
<tr>
<td>V90.83</td>
<td>Retained stone or crystalline fragments</td>
</tr>
<tr>
<td>V90.89</td>
<td>Other specified retained foreign body</td>
</tr>
<tr>
<td>V90.9</td>
<td>Retained foreign body, unspecified material</td>
</tr>
<tr>
<td>V91.00</td>
<td>Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.01</td>
<td>Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)</td>
</tr>
<tr>
<td>V91.02</td>
<td>Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)</td>
</tr>
<tr>
<td>V91.03</td>
<td>Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)</td>
</tr>
</tbody>
</table>
# NEW DIAGNOSIS CODES

**Effective October 1, 2010**

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V91.09</td>
<td>Twin gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.10</td>
<td>Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.11</td>
<td>Triplet gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.12</td>
<td>Triplet gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.19</td>
<td>Triplet gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.20</td>
<td>Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.21</td>
<td>Quadruplet gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.22</td>
<td>Quadruplet gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.29</td>
<td>Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.90</td>
<td>Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.91</td>
<td>Other specified multiple gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.92</td>
<td>Other specified multiple gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.99</td>
<td>Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
</tbody>
</table>

**Notes:**

* These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2010. Please note that new code 237.78, Other neurofibromatosis, that was listed as a new diagnosis code in the proposed rule has been modified to new code 237.79. New code 799.50, Unspecified signs and symptoms involving cognition, that was listed in the proposed rule as a new code has been deleted and will not be implemented on October 1, 2010.

**The code title has changed from the proposed rule.**
**REVISED DIAGNOSIS CODE TITLES**  
**Effective October 1, 2010**

The final addendum providing complete information on changes to the diagnosis part of ICD-9-CM is posted on CDC’s webpage at: www.cdc.gov/nchs/icd9.htm

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>307.0*</td>
<td>Adult onset fluency disorder</td>
</tr>
<tr>
<td>629.81</td>
<td>Recurrent pregnancy loss without current pregnancy</td>
</tr>
<tr>
<td>646.30</td>
<td>Recurrent pregnancy loss, unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>646.31</td>
<td>Recurrent pregnancy loss, delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>646.33</td>
<td>Recurrent pregnancy loss, antepartum condition or complication</td>
</tr>
<tr>
<td>724.02</td>
<td>Spinal stenosis, lumbar region, without neurogenic claudication</td>
</tr>
<tr>
<td>781.8</td>
<td>Neurologic neglect syndrome</td>
</tr>
<tr>
<td>E017.0</td>
<td>Roller coaster riding</td>
</tr>
<tr>
<td>V07.51*</td>
<td>Use of selective estrogen receptor modulators (SERMs)</td>
</tr>
<tr>
<td>V07.52*</td>
<td>Use of aromatase inhibitors</td>
</tr>
<tr>
<td>V07.59*</td>
<td>Use of other agents affecting estrogen receptors and estrogen levels</td>
</tr>
<tr>
<td>V07.8*</td>
<td>Other specified prophylactic or treatment measure</td>
</tr>
<tr>
<td>V07.9*</td>
<td>Unspecified prophylactic or treatment measure</td>
</tr>
<tr>
<td>V13.61</td>
<td>Personal history of (corrected) hypospadias</td>
</tr>
<tr>
<td>V13.69</td>
<td>Personal history of other (corrected) congenital malformations</td>
</tr>
<tr>
<td>V26.35</td>
<td>Encounter for testing of male partner of female with recurrent pregnancy loss</td>
</tr>
</tbody>
</table>

**Notes:**  
* These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2010.
The final addendum providing complete information on changes to the diagnosis part of ICD-9-CM is posted on CDC’s webpage at: www.cdc.gov/nchs/icd9.htm

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>275.0</td>
<td>Disorders of iron metabolism</td>
</tr>
<tr>
<td>276.6</td>
<td>Fluid overload</td>
</tr>
<tr>
<td>287.4</td>
<td>Secondary thrombocytopenia</td>
</tr>
<tr>
<td>488.0*</td>
<td>Influenza due to identified avian influenza virus</td>
</tr>
<tr>
<td>488.1*</td>
<td>Influenza due to identified novel H1N1 influenza virus</td>
</tr>
<tr>
<td>752.3</td>
<td>Other anomalies of uterus</td>
</tr>
<tr>
<td>786.3</td>
<td>Hemoptysis</td>
</tr>
<tr>
<td>787.6</td>
<td>Incontinence of feces</td>
</tr>
<tr>
<td>970.8</td>
<td>Poisoning by other specified central nervous system stimulants</td>
</tr>
<tr>
<td>999.6</td>
<td>ABO incompatibility reaction</td>
</tr>
<tr>
<td>999.7</td>
<td>Rh incompatibility reaction</td>
</tr>
<tr>
<td>V25.1</td>
<td>Encounter for insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V85.4</td>
<td>Body Mass Index 40 and over, adult</td>
</tr>
</tbody>
</table>

Notes: These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be deleted on October 1, 2010.