

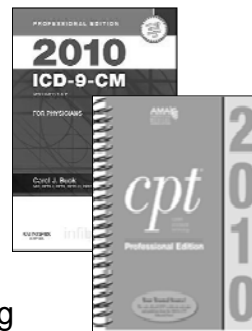
CHCANYS Presents Coding for Clinicians in 2011



Shawn Hafer, CCS-P, CPC
Brown Consulting Associates, Inc.
October 2010

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



Brown Consulting Associates, Inc.

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

coding/patient accounts responsibility for a large Ob-Gyn practice. 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.

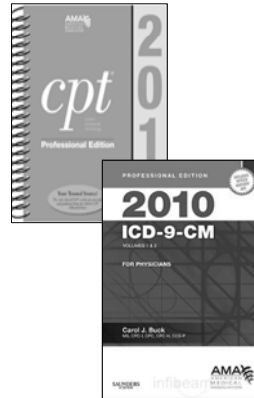
Brown Consulting Associates, Inc.
P.O. Box 468
Twin Falls, ID 83303
Ph 208.736.3755, Fax 208.736.1946

bonnielewis@codinghelp.com
shawnyafer@codinghelp.com
danafox@codinghelp.com
donnaaronroe@codinghelp.com

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.



Brown Consulting Associates, Inc. 2010

3

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!*

Brown Consulting Associates, Inc. 2010

4

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



Copyright Brown Consulting Associates, Inc.

5

The Great (Coding) Delusion ...

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



Brown Consulting Associates, Inc. 2010

6

Who is responsible for correct coding?

The Clinician

The Coder/Biller

The Clinic Administration

7

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.

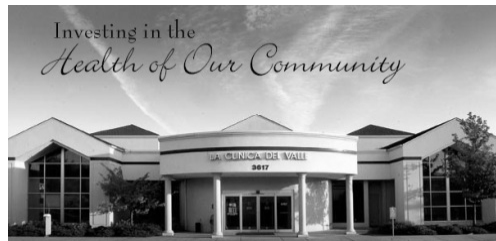
What is the coders role?

Be sure the codes submitted are correct!

Brown Consulting Associates, Inc. 2010

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

Copyright Brown Consulting Associates, Inc. 2010

11

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.

Copyright Brown Consulting Associates, Inc. 2010

12

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

Brown Consulting Associates, Inc. 2010

15

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).

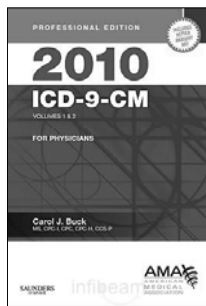
Not automatically true for Medicaid.

Copyright Brown Consulting Associates, Inc. 2010

16

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.

Brown Consulting Associates, Inc. 2010

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.

Brown Consulting Associates, Inc. 2010

20

Diagnosis Coding Accuracy: Example From 2010 BCA Initial Audits of Clinics

Error %	Error Code	Error Description
39%	1.2	Dx in record not reported for billing
26%	1.1	Dx reported for billing not documented
26%	1.4	Dx reported as #1 does not match record
9%	1.5	Dx reported for billing lacks specificity
0%	1.3	Dx reported for billing is documented unconfirmed

Brown Consulting Associates, Inc. 2010

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.

Brown Consulting Associates, Inc. 2010

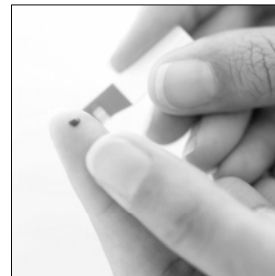
22

Sample Dx Coding Issues

- Back pain coded but was encounter for opiate management.
- Late effects of CVA (18months 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

HTN, essential or unspecified	401.x
Hypertensive heart disease	402.xx
with heart failure, type:	
Hypertensive CKD	403.xx
CKD stage:	
Hypertensive heart dz & CKD	404.xx
with heart failure, type:	
CKD stage:	
4th digits: 9=unsp. 0=malignant 1=benign	

Category 402 5th digits:
 0= without heart failure
 1= with heart failure

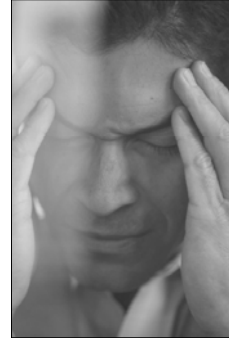
Use additional code to identify the stage of chronic kidney disease:

- 585.1 Chronic kidney disease, Stage I
- 585.2 Chronic kidney disease, Stage II (mild)
- 585.3 Chronic kidney disease, Stage III (mod)
- 585.4 Chronic kidney disease, Stage IV (severe)
- 585.5 Chronic kidney disease, Stage V
- 585.6 End stage renal disease (needs dialysis)
- 585.9 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.



Brown Consulting Associates, Inc. 2010

29

Pain Management

- 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...

Brown Consulting Associates, Inc. 2010

30

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



Brown Consulting Associates, Inc. 2010

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.

Brown Consulting Associates, Inc. 2010

32

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

Brown Consulting Associates 2010

37

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)



Brown Consulting Associates, Inc. 2010

38

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)

Brown Consulting Associates, Inc. 2010

39

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).

Brown Consulting Associates, Inc. 2010

40

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.
- Reference Sections I and IV of the Official ICD-9-CM Coding guidelines. Published in most ICD-9-CM code books, or online at <http://www.cdc.gov/nchs/icd.htm>.
- 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



Brown Consulting Associates, Inc. 2010

45

ICD-10-CM for 2013

An Introduction



46

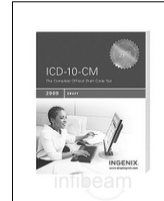
ICD-10-CM

- Final rule published January 16, 2010, requires implementation on October 1, 2013.
 - 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/abtcd10.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

Brown Consulting Associates, Inc. 2010

51

Similarities and Differences

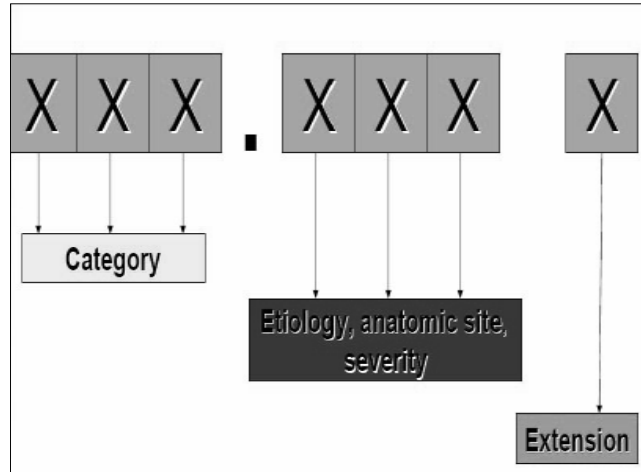
- Much of what you see in ICD-10-CM will be familiar:
 - Rubric system
 - Index conventions
 - Tabular conventions
 - Includes notes
 - Inclusion terms
 - Neoplasm table
- Some areas will be significantly changed compared to ICD-9-CM:
 - Injuries
 - Combined codes
 - Reassignment of existing codes to new categories
 - Alpha extensions
 - Excludes note changes
 - Some changes to guidelines

Brown Consulting Associates, Inc. 2010

52

ICD-10-CM Structure:

3 to 6 position code with leading alpha (+ extension)



Brown Consulting Associates, Inc. 2010

53

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*

Brown Consulting Associates, Inc. 2010

54

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

Clinician Benefits	Clinician Risks
Better profiling due to the specificity of data collected	Medical terminology challenges in documentation
Improved clinical information for research	Increased documentation requirements
Clearer code choices	Increased queries for coding clarification
Clearer reimbursement guidelines	Reimbursement delays

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

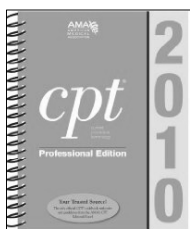
ICD-10-CM Clinical Preparedness

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
 - Oct 2012 – Jan 2013 Finalize ICD-10-CM Training
 - Jan–Sept 2013 - Coders should have ICD-9 & ICD-10 code books and be given time to review/code some claims from both.
 - Jan-Sept 2013 – Intensive re-training/evaluation related to ICD-10-CM competence.

E/M Visit Coding

Evaluation and Management (E/M) Level of Service



2010 Brown Consulting - E/M Range Card		Use the Audit Bar	
Visit Type	Code	History	Physical
New Patient	99201-99203	9-12	1-12
Established Patient	99211-99213	4-12	1-12
Initial	99241-99243	9-12	1-12
Subsequent	99251-99253	4-12	1-12
Emergency	99281-99283	4-12	1-12
Office	99291-99293	4-12	1-12
Home	99341-99343	4-12	1-12
Telephone	99421-99423	4-12	1-12
Telehealth	99431-99433	4-12	1-12

59

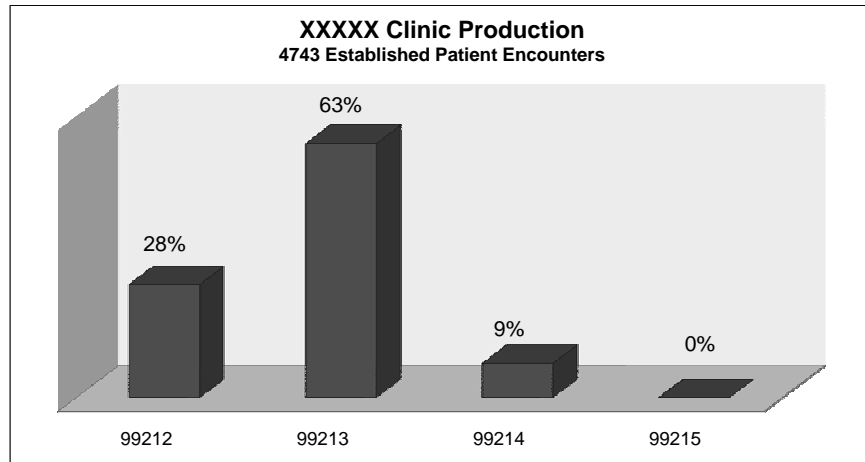
Evaluation/Management Services

- 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.
 - http://cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Brown Consulting Associates, Inc. 2010

60

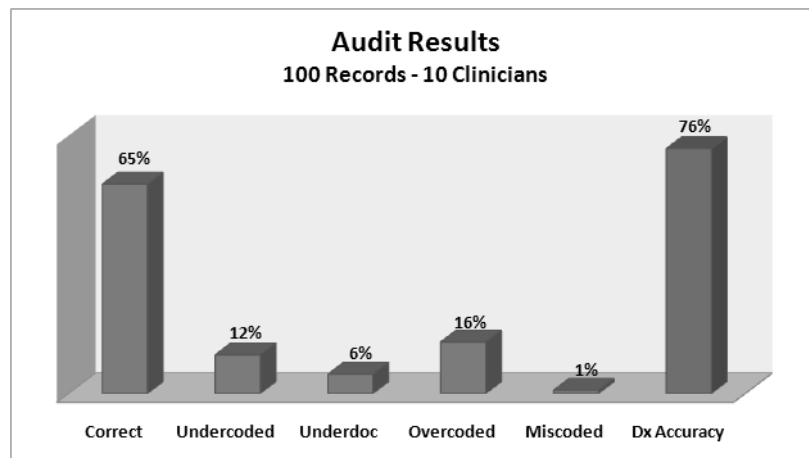
E/M Production



Brown Consulting Associates, Inc. 2010

61

Example: Collective E/M Audit Results



Brown Consulting Associates, Inc. 2010

62

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?

Brown Consulting Associates, Inc. 2010

65

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...

Brown Consulting Associates, Inc. 2010

66

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).

Brown Consulting Associates, Inc. 2010

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.



68

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...”

Brown Consulting Associates, Inc. 2010

71

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...*”



Brown Consulting Associates, Inc. 2010

72

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.
- Exam: BP 156/98, 88, 18. RRR, 2+ edema.
- **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.

Brown Consulting Associates, Inc. 2010

73

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 xxcontraceptive vaginal ring.
2. High risk sexual behavior



Plan: Continue method, return as scheduled.

Brown Consulting Associates, Inc. 2010

74

The Three Key Components

1. History
2. Exam
3. Medical Decision Making



A Solution for Compliant E/M Coding

2010 Brown Consulting - E/M Recipe Card								<i>Use the back first</i>	
Est Patient	MDM	2 of 3	HISTORY	OR	EXAM	Est. Pt	Time GL	HPI Qualifiers	
Straightforward	MDM	CC & HPI (1-3 qualifiers)	See HPI		1 system/area	99212	10 min	1	Location
Low Complexity	MDM	CC, HPI x1-3 qualifiers and ROS x1 system			2-4 systems/areas	99213	15 min	2	Duration
Moderate Complex	MDM	CC, HPI x4 qualifiers, ROS x 2-9 systems, and pertinent Medical, Family or Social			1 sys/area detailed and 4-6 oth	99214	25 min	3	Severity
High Complexity	MDM	CC, HPI x4, ROS x10, 2 Hxs: (Med. Soc. Fat			8 or > systems	99215	40 min	4	Quality
Nurse Visit		Nurse or MA. Some payers require clinician to be in office				99211	5 min or >	5	Context
								6	Additional S/S
								7	Modifying factors
								8	Timing
New Patient	MDM	All 3	HISTORY	AND	EXAM	New Pt	Time GL	Consult	Time
Straightforward	MDM	CC & HPI (1-3 qualifiers)			1 system/area	99201	10 min	99241	15 min
Straightforward	MDM	CC, HPI x1-3 qualifiers and ROS x1 system			2-4 systems/areas	99202	20 min	99242	30 min
Low Complexity	MDM	CC, HPI x4, ROS x2-9 sys., 1 Hx: (Med Soc			1 sys/area detailed + 4	99203	30 min	99243	40 min
Moderate Complex	MDM	CC, HPI of at least 4 qualifiers, ROS of 10			8 or more body systems	99204	45 min	99244	60 min
High Complexity	MDM	sys and all Medical, Family & Social			systems	99205	60 min	99245	80 min

Ex requirements.

stable today

an acute uncomplicated

worse/not responding to treatment

as

or 1 significant problem worse with other problem(s)

or 1 or more new significant problem(s)

or undiagnosed new problem with uncertain outcome

HIGH 99216 (New: 99205) Severe exacerbation, life threatening, neuro changes

Combo of multiple new, est/worsening & est/stable

Usually with several labs, x-rays, dx tests, record reviews +*...

◆ BCA Recipe Card guides to code accuracy in 95% of audited cases.

◆ See also CPT and CMS 1995 and 1997 Guidelines.

© Brown Consulting Associates, Inc. 205-735-3755 Order: kernrobbsa@codinghelp.com Rev 3-15-10

Body Systems	
1 Con	2 Skin
3 Eyes	4 ENT
5 Lymph	6 CV
7 Resp	8 GI
9 GU	10 MS
11 Neuro	12 Endo
13 Hems/Imm	
14 Psychiatric	

Documenting Based on Time

1. Document code to total time
2. Prove > 50% counseling
3. Identify counseling content

...15 of 25 min. counseling re: diabetes & various tx options...

Assessment: New Type II DM
Plan: Diet, meds, DMEducator

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*

77

Brown Consulting Associates, Inc. 2010

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.



Brown Consulting Associates, Inc. 2010

78

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



Brown Consulting Associates, Inc. 2010

79

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.

Brown Consulting Associates, Inc. 2010

80

MDM Recipe

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

STRAIGHTFORWARD 99212 (New: 99201 or 99202)	1 significant/simple problem stable or improving, or 1 minor problem today
LOW MDM 99213 (New: 99203)	2 stable/moroved/minor or an acute uncomplicated illness such as bronchitis, UTI, OM... or 1 problem worsening/not responding to tx
MODERATE 99214 (New: 99204)	3 or more chronic stable or unstable problems or 1 significant problem worse with other problem(s) or 1 or more new significant problem(s) or undiagnosed new problem with uncertain outcome
HIGH 99215 (New: 99205)	Severe exacerbation, life threatening, neuro changes Combo of multiple new, est/worsening & est/stable

Usually with several labs, x-rays, dx tests, record reviews ++...

- ◆ Review BCA Wallpaper, CPT Guidelines and CMS Guidelines.
- ◆ This tool is intended for clinician use after training.

© Brown Consulting Associates, Inc. 208-738-3755 Order: karrinob@codinghelp.com Rev 2-24-10

Body Systems
Con, Skin, Eyes,
ENT, Lymph, CV,
Resp, GI, GU,
MS, Neuro, Hem,
Imm, Endo,
Psych.



Documenting Based on Time

1. Document/code total time
 2. Prove > 50% counseling
 3. Identify counseling content
- *15 of 25 min. counseling regarding
DM & various treatment options...
Assessment: New Type II DM
Plan: Diet, meds, DM Educator

Brown Consulting Associates, Inc. 2010

81

Hx and Ex Recipe

2010 Brown Consulting - E/M Recipe Card *Use the back first*

Established Pt.	EXAM	OR	HISTORY	2 of 3	Est. Pt. Time	GL	HPI Qualifiers
Straightforward MDM	1 system	CC & Brief HPI (1-3 HPI qualifiers)	See HPI →	99212	10 min		Location, duration, severity, quality,
Low Complexity MDM	2-4 systems	CC, HPI x1-3 qualifiers and ROS x1 system		99213	15 min		context, add'l G/S,
Moderate Complex MDM	*1 Detail + 4-6	CC, HPI x4, ROS x2 sys., 1 Hx: (Med. Soc. Fam.)		99214	25 min		modifying factors,
High Complexity MDM	8 or > sys	CC, HPI x4, ROS x10, 2 Hxs: (Med. Soc. Fam.)		99215	40 min		and timing:
Nurse, MA or "very minimal" by clinician		Documented asmt. & management. Clinician is in.		99211	3 min or >		Max required = 4
New Patient MDM	EXAM	AND	HISTORY	All 3	New Pt. Time	GL	Consult: Time
Straightforward MDM	1 system	CC & Brief HPI (1-3 HPI qualifiers)	See HPI	99201	10 min		99241 15 min
Straightforward MDM	2-4 systems	CC, HPI x1-3 qualifiers and ROS x1 system		99202	20 min		99242 30 min
Low Complexity MDM	*1 Detail + 4-6	CC, HPI x4, ROS x2 sys., 1 Hx: (Med. Soc. Fam.)		99203	30 min		99243 40 min
Moderate Complex MDM	8 or > sys	CC, HPI x4, ROS x10, 3 Hxs: (Med. Soc. Fam.)		99204	45 min		99244 60 min
High Complexity MDM	8 or > sys	CC, HPI x4, ROS x10, 3 Hxs: (Med. Soc. Fam.)		99205	60 min		99245 80 min

© Brown Consulting Associates, Inc. *Exam one system detailed plus some exam of 4-6 other system. See your Mcare site. www.codinghelp.com

Brown Consulting Associates, Inc. 2010

82

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

2010 Brown Consulting - E/M Recipe Card *Use the back first*

Est Patient MDM	2 of 3	HISTORY	OR	EXAM	Est. Pt	Time GL	HPI Qualifiers
Straightforward MDM	CC & HPI (1-3 qualifiers)	See HPI		1 system/area	99212	10 min	1 Location
Low Complexity MDM	CC, HPI x1-3 qualifiers and ROS x1 system			2-4 systems/areas	99213	15 min	2 Duration
Moderate Complex MDM	CC, HPI x4 qualifiers, ROS x 2-9 systems, and pertinent Medical, Family or Social			1 sys/area detailed and 4-6 oth	99214	25 min	3 Severity
High Complexity MDM	CC, HPI x4, ROS x10, 2 Hxs: (Med. Soc. Fam)			8 or > systems	99215	40 min	4 Quality
Nurse Visit	Nurse or MA. Some payers require clinician to be in office.				99211	5 min or >	5 Context
							6 Additional S/S
							7 Modifying factors
							8 Timing

Brown Consulting Associates 2010

83

E/M Suggestions

- 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).

New Patient MDM	All 3	HISTORY	AND	EXAM	New Pt	Time GL
Straightforward MDM	CC & Brief HPI (1-3 HPI qualifiers)			1 system	99201	10 min
Straightforward MDM	CC, HPI x1-3 qualifiers and ROS x1 system			2-4 systems	99202	20 min
Low Complexity MDM	CC, HPI x4, ROS x2 sys., 1 Hx: (Med. Soc. Fam)			1 detailed sys + 4-6	99203	30 min
Moderate Complex MDM	CC, HPI of at least 4 qualifiers, ROS of 10 sys			8 or more body	99204	45 min
High Complexity MDM	and all Medical, Family & Social History			systems	99205	60 min

Brown Consulting Associates 2010

84

Focus on Wellness

99381-99397

The patient presents to confirm wellness.

- Annual PAP/Pelvic
- Well Child
- Immigration
- Drivers
- Pilot
- Sports (99499 vs. 993XX-52)



Brown Consulting Associates, Inc. 2010

85

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.



Brown Consulting Associates, Inc. 2010

86

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.



Brown Consulting Associates, Inc. 2010

87

Wellness and Illness Same Date

- 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!



Brown Consulting Associates, Inc. 2010

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.”*

Brown Consulting Associates, Inc. 2010

89

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.)*



Brown Consulting Associates, Inc. 2010

Surgery Coding

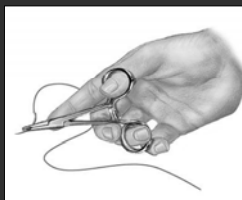
E/M and Surgery on the Same Date



Brown Consulting Associates, Inc. 2010

91

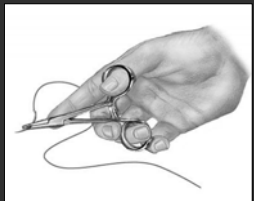
Code E/M and Surgery



- 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.

Brown Consulting Associates, Inc. 2010

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.

Brown Consulting Associates, Inc. 2010

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.

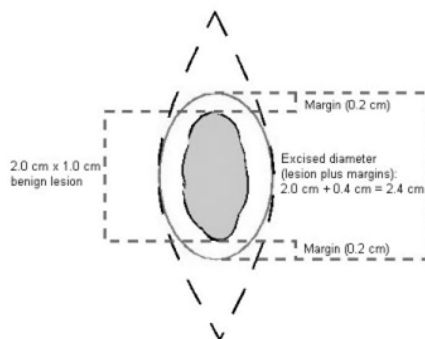
Copyright Brown Consulting Associates, Inc.

94

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”

Example: excision of benign lesion of neck, 1.0 cm x 2.0 cm. Code 11423



Picture Copyright CPT 2010

Brown Consulting Associates, Inc. 2010

95

Coding Accuracy Matters

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

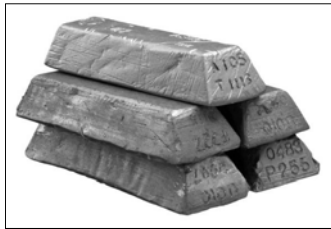
Code	Procedure (See CPT)	RVU
12001	Repair 2.5cm, simple	3.85
12031	Repair 2.5cm, intermediate	6.12
17000	Destroy skin lesion	2.04
54056	Destroy penile lesion	3.65
96372	IM injection	0.59
20610	Joint injection	1.98

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4>

Copyright Brown Consulting Associates, Inc.

96

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

- “CPT” is a registered trademark of the American Medical Association. Their codes, descriptions and manual content are copyright by the AMA. All rights are reserved by the AMA.
- 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.

99

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

Diagnosis Code	Description
237.73	Schwannomatosis
237.79*	Other neurofibromatosis
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
276.61	Transfusion associated circulatory overload
276.69	Other fluid overload
278.03	Obesity hypoventilation syndrome
287.41	Posttransfusion purpura
287.49	Other secondary thrombocytopenia
315.35*	Childhood onset fluency disorder
447.70	Aortic ectasia, unspecified site
447.71	Thoracic aortic ectasia
447.72	Abdominal aortic ectasia
447.73	Thoracoabdominal aortic ectasia
488.01*	Influenza due to identified avian influenza virus with pneumonia
488.02*	Influenza due to identified avian influenza virus with other respiratory manifestations
488.09*	Influenza due to identified avian influenza virus with other manifestations
488.11*	Influenza due to identified novel H1N1 influenza virus with pneumonia
488.12*	Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations
488.19*	Influenza due to identified novel H1N1 influenza virus with other manifestations
560.32	Fecal impaction
724.03	Spinal stenosis, lumbar region, with neurogenic claudication
752.31	Agenesis of uterus
752.32	Hypoplasia of uterus
752.33	Unicornuate uterus
752.34	Bicornuate uterus
752.35	Septate uterus
752.36	Arcuate uterus
752.39	Other anomalies of uterus
752.43	Cervical agenesis
752.44	Cervical duplication
752.45	Vaginal agenesis
752.46	Transverse vaginal septum
752.47	Longitudinal vaginal septum
780.33	Post traumatic seizures
780.66	Febrile nonhemolytic transfusion reaction

NEW DIAGNOSIS CODES
Effective October 1, 2010

Diagnosis Code	Description
784.52*	Fluency disorder in conditions classified elsewhere
784.92	Jaw pain
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
786.39	Other hemoptysis
787.60	Full incontinence of feces
787.61	Incomplete defecation
787.62	Fecal smearing
787.63	Fecal urgency
799.51	Attention or concentration deficit
799.52	Cognitive communication deficit
799.53	Visuospatial deficit
799.54	Psychomotor deficit
799.55	Frontal lobe and executive function deficit
799.59	Other signs and symptoms involving cognition
970.81	Poisoning by cocaine
970.89	Poisoning by other central nervous system stimulants
999.60	ABO incompatibility reaction, unspecified
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.62	ABO incompatibility with acute hemolytic transfusion reaction
999.63	ABO incompatibility with delayed hemolytic transfusion reaction
999.69	Other ABO incompatibility reaction
999.70	Rh incompatibility reaction, unspecified
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.72	Rh incompatibility with acute hemolytic transfusion reaction
999.73	Rh incompatibility with delayed hemolytic transfusion reaction
999.74	Other Rh incompatibility reaction
999.75	Non-ABO incompatibility reaction, unspecified
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction
999.79	Other non-ABO incompatibility reaction
999.80	Transfusion reaction, unspecified
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
E000.2	Volunteer activity
V11.4	Personal history of combat and operational stress reaction
V13.23	Personal history of vaginal dysplasia
V13.24	Personal history of vulvar dysplasia

NEW DIAGNOSIS CODES
Effective October 1, 2010

Diagnosis Code	Description
V13.62	Personal history of other (corrected) congenital malformations of genitourinary system
V13.63	Personal history of (corrected) congenital malformations of nervous system
V13.64	Personal history of (corrected) congenital malformations of eye, ear, face and neck
V13.65	Personal history of (corrected) congenital malformations of heart and circulatory system
V13.66	Personal history of (corrected) congenital malformations of respiratory system
V13.67	Personal history of (corrected) congenital malformations of digestive system
V13.68**	Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal systems
V15.53	Personal history of retained foreign body fully removed
V25.11	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device
V49.86	Do not resuscitate status
V49.87*	Physical restraints status
V62.85	Homicidal ideation
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult
V88.11	Acquired total absence of pancreas
V88.12	Acquired partial absence of pancreas
V90.01	Retained depleted uranium fragments
V90.09	Other retained radioactive fragments
V90.10	Retained metal fragments, unspecified
V90.11	Retained magnetic metal fragments
V90.12	Retained nonmagnetic metal fragments
V90.2	Retained plastic fragments
V90.31	Retained animal quills or spines
V90.32	Retained tooth
V90.33	Retained wood fragments
V90.39	Other retained organic fragments
V90.81	Retained glass fragments
V90.83	Retained stone or crystalline fragments
V90.89	Other specified retained foreign body
V90.9	Retained foreign body, unspecified material
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)
V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)

NEW DIAGNOSIS CODES
Effective October 1, 2010

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

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

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

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.

INVALID 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

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

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.

BCA 2010 ENCOUNTER FORM EXAMPLE

A Established Patients				2 of 3 or time		Counseling Time		H Surgical Procedures		J Injections		
1 MDM	2 HISTORY	3 EXAM	CODE TIME	CODE TIME		for E/Ms A & B						
Straight	CC, HPIx1-3	1 system	99212 10			 Select code based on total time.		10160	Aspirate abscess/cyst	<i>Code injection and product (J code)</i>		
Low	CC, HPIx1-3, ROSx1 sys	2-4 systems	99213 15					11100	Skin/Punch bx (one bx)	<i>See CPT and Medicare rules for injections with "nurse visits"</i>		
Mod	CC, HPIx4, ROSx2 sys, pertinent hx (Med/Fam/Soc)	1 sys detailed & 4-6 oth sys	99214 25			Document 1. Total time 2. > 50% counsel 3. Content		11101	ea add'l lesion # _____	95115	Allergy svc, 1 injection	
High	CC HPIx4, ROSx10 1 hx	8 or > sys	99215 40					11200	Skin tags (1-15)	95117	multiple injections	
"Nurse"	MCare - clinician in office		99211 5					11201	ea add'l 10 # _____	96372	IM or SQ injection	
Post Op	Aftercare PO following surgery by you		99024					17000	Destroy 1st lesion	IV Services		
No Chg	Reason		Rare					17003	2nd-14th, ea. # _____	<i>See CPT for detailed infusion rules</i>		
B New Patients (not in clinic past 3 yrs)				All 3 or time		Consultation						
1 MDM	2 HISTORY	3 EXAM	CODE TIME	CODE TIME								
Straight	CC, HPIx1-3	1 system	99201 10	99241 15	No Con. for Medicare				10060	I&D, abs. simple/one	96360	IV Hydration 31-60 min
Straight	CC, HPIx1-3, ROSx1 sys	2-4 systems	99202 20	99242 30			10061	I&D, abs. comp/multiple	96361	each add'l hour		
Low	CC, HPIx4, ROSx2 sys, pertinent hx (Med/Fam/Soc)	1 sys detailed & 4-6 oth sys	99203 30	99243 40			10140	I&D, hematoma	96365	Infusion, <1 hour		
Mod	CC, HPIx4, ROSx10 sys	8 or > body systems	99204 45	99244 60			10080	I&D pilonidal cyst	96366	each add'l hour		
High	All Med/Fam/Soc Hxs		99205 60	99245 80			See CPT	Foreign body removal	Injectable Drugs			
C Wellness (Preventive)				MCare Part B Specific								
<i>May code w/low E/M-25. Write an extra paragraph w/add'l hx or exam & MDM</i>				<i>Patient eligible during 1st 12 months in Medicare. May bill also a screening EKG G0403-G0405</i>								
Est.	Age	New	G0402	"Welcome to Medicare" IPPE								
99381	< 1 year old	99391	<i>Medicare breast/pelvic/Pap: Q2 years or annually with published risk factors. Need ABN?</i>				54056	Destroy penis les by cryo	J3301	Kenalog per 10 mg		
99382	1-4 years	99392	<i>May code w/other E/M as appropriate; -25 on E/M. Get ABN if last date uncertain.</i>		Diagnosis		46900	anal lesion(s) by chem	J1940	Lasix per 20 mg		
99383	5-11 years	99393	G0101	Breast/pelvic Q2yrs	V76.2		46916	by cryosurgery	J0696	Rocephin per 250 mg		
99384	12-17 years	99394	G0101	annual if high risk	V15.89		51701	Cath., straight/residual	J1885	Toradol 15 mg		
99385	18-39 years	99395	Q0091	Mcare PAP collection	V76.2		51702	Catheter, Foley	K Immunizations			
99386	40-64 years	99396	<i>See CPT Hemorrhoids Inc Exc ?</i>				Surgery Requiring Detail		<i>Code administration and vaccine(s)</i>			
99387	65 + years	99397	<i>Document time where appropriate</i>				Excision Loc: _____		90465	Dr. counsels, pt <8 yrs.		
D Smoking Cessation												
<i>Do not use with C above. Services included in E/M. Coverage varies.</i>												
99406	Smoking cessation intermediate (clinician & patient)		>3-10 min							90466	each add'l CPT below	
99407	Smoking cessation intensive (clinician & patient)		>10 min							90471	Admin any 1 CPT below	
E ETOH/Substance												
<i>CPT MCARE May be coded with E/M if addressing other problem.</i>												
<i>ETOH/substance screening with (AUDIT, DAST) & brief intervention (SBI) services</i>												
99408	G0396	Choose code by documented time	15-30 min							90472	each add'l CPT below	
99409	G0397	Choose code by documented time	> 30 min							Vaccines (code with admin.)		
F Diagnostic & Treatment Service				G In House Labs								
94640	Nebulizer (multi tx use -76)		36415	Venipuncture						90700	DTaP (< 7 yrs) V06.1	
94664	Nebulizer use, patient training		36416	Finger/heel stick						90715	Tdap >7 yrs (Boostrix)	
94010	Spirometry		82948	Glucose, finger stick						90723	DtaP-HepB-IPV (Pediarix) V06.8	
94060	Brosptasm eval, pre/post dilators		83036	Glycated HbA1C						90633	Hep A peds/adol. (2 dose)	
94620	Pulm stress test, (eg, exercise)		82270	Hemoccult						90744	Hep B peds/adol. (3 dose)	
94760	Pulse oximetry, single		87220	KOH (skin/hair/nails)						90743	Hep B adol.(2 dose) V05.3	
93000	EKG, 12 lead (trace, interp & rpt)		81025	Urine pregnancy						90746	Hep B (Mcare adm G0010)	
93005	EKG, 12 lead (trace only) [FOHC MC]		87880	Rapid strep (visual)						90648	Hib PRP-T (4 dose) V03.81	
93010	EKG, 12 lead (interp & rpt only)		86580	TB skin test						90657	Flu split 6-35 mos V04.81	
93040	Rhythm ECG w/ interp & report		81002	UA/Dip						90657	Flu split 3yr-adult V04.81	
93041	Rhythm ECG (trace only) [FOHC MC]		81000	UA/Micro						90658	Flu split (MC adm G0008)	
93015	Cardiac stress w/ interp & report		87210	Wet mount						90663	H1N1 flu Admin. 90470	
93230	Holter monitor with interp & rpt		80050	General health panel						G9142	H1N1 (Mcare adm G9141)	
92567	Tympanometry, both ears (1 = -52)		80055	OB panel						90713	IPV V04.0	
92551	Audiometry, air, both ears (1 = -52)		80061	Lipid panel						90707	MMR V06.4	
99173	Visual acuity screen, quant, bilat.		Other							90669	Pneumo 7-valent IM	
I Female Surgery												
										90732	Pneumo (MC adm G0009)	
57500	Cervical bx(s)								90718	Td (> 7 yrs) V06.5		
58100	Endometrial biopsy								90703	Tetanus toxoid V03.7		
57511	Cautery/cryo cervix								90716	Varicella vaccine V05.4		
57420	Colpo vagina w/cervix								90736	Zoster vaccine V04.89		
57421	w/bx(s) vag or cervix											
57452	Colpo cerv w/adj vag											
57455	w/bx(s) cervix											
57456	w/endocerv cur. ECC											
57454	w/bx(s) cervix & ECC											
57061	Destroy vag lesion(s)											
58300	Insert IUD +IUD V25.1											
58301	Remove IUD V25.42											
Other												