



CDPHE - Women's Health Conference 2015

Coding & Billing Workshop

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Meet Your Presenter



Toni Woods, CCS, CPC, AHIMA
Approved ICD-10-CM/PCS Trainer

Ms. Woods is a nationally known speaker and educator and has extensive auditing, coding and billing experience in a wide variety of specialties, including but not limited to, Primary Care, Public Health, Orthopedic Surgery, Neurosurgery, General Surgery, Oncology, etc.

When she's not working, Toni enjoys playing poker, tennis, and traveling.



Learning Objectives

- What are the ICD-9-CM, CPT, and HCPCS code sets?
- Modifier usage
- Brief ICD-9 Overview
- Specifics of auditing provider documentation and compliance
- E/M Review with discussion of the 3 key components determining evaluation and management codes: history, physical exam, medical-decision-making
- Discuss time-based coding as it pertains to E/M services
- ICD-10 Overview specific to family planning
- Discuss GEMs
- Review of ICD-10-CM Concept Changes & Additions by chapter pertinent to family planning
- Code Specific Documentation Examples
- Dissect your notes together
- Questions



Why are codes used?

You already know...Coding provides a description of diseases, illnesses, injuries and procedures

- Tracking of mortality and morbidity rates and statistical data
- Track DX treated by providers
- Communicate with payers for payment
 - Coding allows payers to evaluate resources
 - Develop quality measures
 - Assist in the treatment of conditions
- Provides the following information:
 - **What** service(s) was provided?
 - **Why** the service(s) was provided?
 - Increasingly – **What** works and what does not!



Code Sets

3 different code sets used for reporting diagnosis coding, procedure coding, and supplies/other services:

- ICD-9-CM
- CPT
- HCPCS



ICD-9-CM

- Defines **why the patient came in** for services
- **Communicates medical necessity** to the payer
- 3-5 digit code(s)
- Code selection should be made based on the highest level of specificity
- Example: Generalized abdominal pain
 - 789.07-Abdominal pain, generalized
 - Code requires all 5 digits to consider valid

Will be replaced by ICD-10-CM on October 1, 2015.



CPT - Current Procedural Terminology

- Defines **what services were furnished** to the patient
- 5 digit code that can describe anything from an office visit to knee surgery
- **Code selection should be based on the documentation requirements for each procedural service**
- Example: Patient presents for IUD removal.
 - Bill: **11982-Removal, non-biodegradable drug delivery implant**



HCPCS

Healthcare **C**ommon **P**rocedure **C**oding **S**ystem

- Used mostly for supplies
- Example: Patient receives Nexplanon implant
- Bill: J7307-Etonogestrel (contraceptive) implant system, including implant and supplies



Modifiers

- Modifiers help to **“tell the story”** of the claim
- Either numeric or alpha-numeric
- Utilize new modifiers when applicable



Modifiers

- **Modifier 33 – Preventive Services**
 - Created in response to healthcare reform
 - Used when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Service Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory).
 - Not used when the service is already identified as preventive (i.e. screening mammography)
 - Identifies to a payer that patient cost-sharing does not apply.
 - Modifier waives copay, deductible, co-insurance, etc.
 - Example of use: Tobacco-use counseling in pregnancy



Modifiers – Women’s Wellness Connection Specific

- **Modifier TC – Technical Component**

- Append to imaging codes (i.e. mammograms, ultrasounds)
- Technical component of the diagnostic service
- Reported when only the equipment is provided

- **Modifier 26 – Professional Component**

- Append to imaging codes (i.e. mammograms, ultrasounds)
- Professional component of the diagnostic service
- Reported when only the reading/interpretation is provided



Modifiers

- **Modifier 25 – Significant and Separately Identifiable Service provided on same day as other E/M service or PX**
 - Append to CPT Codes 99201 – 99499
 - Used to reflect separate services provided at the same encounter
- **Modifier 59 – Distinct Procedural Service**
 - Append to procedures ONLY
 - Used to reflect separate procedural services provided at the same encounter
- **FP – Family Planning Service**



Modifier 25 - Coding Scenario

Established patient who had an IUD inserted 2 years ago, but is now experiencing bleeding and cramping. They discuss removal of the IUD and other possible contraceptive methods. After discussion, the patient requests OCPs. The NP removes the IUD and dispenses birth control pills.

- Provider should code for (CPT and Dx Code):
 - 99213- 25 - 626.4 – bleeding and cramping
 - V25.01 – Initial prescription of OCPs
 - 58301 – V25.12 – IUD removal



Modifier 59 - Coding Scenario

NP removes an IUD and places a nexplanon at the same encounter.

Provider should code for (CPT and Dx Code):

- 58301 – V25.12 – IUD removal
- 11981 – 59 – V25.5 – nexplanon insertion



Use of FP Modifier

- Must be reported with a family planning diagnosis code (V25-V26, V45)
- Should be reported with all family planning services:
 - Patient visits for the purpose of family planning
 - IUD, IUC insertions
 - Tubal ligations
 - Vasectomies
 - Contraceptive drugs or devices
 - Treatment for complications resulting from previous family planning services
 - Labs, radiology, and drugs associated with family planning services



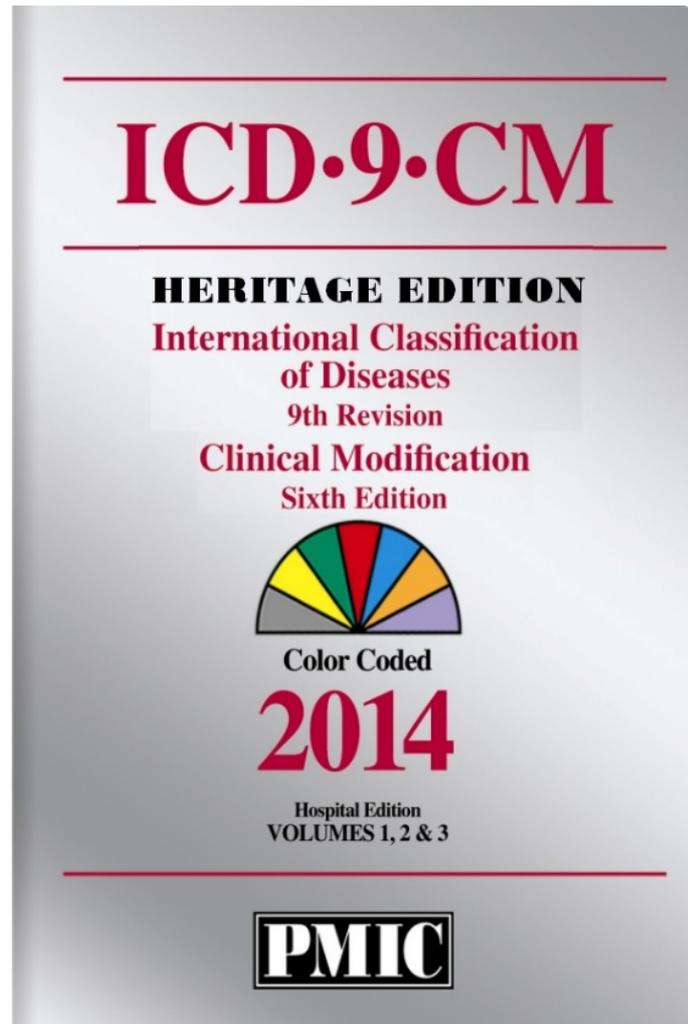
Modifier FP - Coding Scenario

Established patient who has been using diaphragm for 2 years, but is interested in trying OCPs. The NP dispenses birth control pills.

- Provider should code for (CPT and Dx Code):
 - 99213- FP - V25.01 – Initial prescription of OCPs



Brief ICD-9-CM Overview





Official Coding Conventions

- **NOS: Not otherwise specified**
 - Used as the unspecified option when the coder lacks the information necessary to code more specifically
- **NEC: Not elsewhere classified**
 - Used when the ICD-9 code set does not provide a code specific for the patient's condition.



Official Coding Conventions

- **Includes:** Further defines or clarifies the content of the chapter or disease
 - **Example:** 477.9 – Allergies NOS
 - **INCLUDES:** Hay fever, allergic rhinitis
- **Excludes:** *Not classified to the chapter or disease. Always italicized.*
 - **Example:** 311- Depression
 - *Excludes: Acute reaction to major stress with depressive symptoms (308.0)*



Official Coding Conventions

Use additional code: Used to signal the coder that another additional code may be necessary to fully define the disease process or condition. If the condition that is indicated in the note is present in the documentation, it should always be assigned.

- **Example: 599.0 Urinary tract infection, site not specified**
- **Use additional code to identify organism, such as Escherichia coli [E.coli] (041.4)**



Official Coding Conventions

Code First Underlying Condition: Represents what is known as the "Manifestation/Etiology" sequencing rule. When a particular condition is due to another underlying causal condition, the underlying condition (etiology) code is sequenced first, followed by the code for the manifestation. A manifestation code can never be sequenced as the first-listed or principal diagnosis.

– **Example:**

- **V85.43** Body Mass Index 50.0-59.9, adult

– **Code first underlying medical condition:**

- Overweight (278.02)
- Obesity (278.00-278.02)



Official Coding Conventions

Additional Digits Required:

-4th –Indicates that the code requires a fourth digit

-5th –Indicates that the code requires a fifth digit

***Not optional and the highest level of specificity should be selected when coding.**



General Coding Guidelines

- **Signs and Symptoms:**

Signs & Symptoms: Anxiety

- Excessive worry
- Irritability
- Sleep disturbance
- Poor concentration
- Restlessness
- Muscle tension
- Fatigue

Adapted from DSM-IV-TR (2009) p.476.

- Acceptable for reporting when a related definitive diagnosis has not been established by the provider
- **Chapter 16** contains the majority of the signs and symptoms codes



General Coding Guidelines

Combination Code: Single code used to classify:

- Two diagnoses, or
- A diagnosis with an associated secondary manifestation, or
- A diagnosis with an associated complication

Assign only the combination code when the code fully identifies the diagnostic conditions involved



General Coding Guidelines

Combination Code Example:

- Anxiety – 300.00
- Depression – 311
- **Depression with anxiety – 300.4**

***When these two conditions are present together, the combination code should be reported only**



Chapter 1: Infectious and Parasitic Diseases

- HPV
 - 079.4: Human Papillomavirus
- Syphilis
 - 097.0: Late syphilis
 - 097.1: Latent syphilis, unspecified
 - 097.9: Syphilis, unspecified
- Herpes Simplex
 - 054.9: Herpes Simplex Infection without complication



Chapter 1: Infectious and Parasitic Diseases

- Gonococcal infections:
 - 098.0: Gonococcal infection of lower genitourinary tract
 - 098.10: Gonococcal infection (acute) of upper genitourinary tract, site unspecified
 - 098.15: Gonococcal cervicitis (acute)
 - 098.16: Gonococcal endometritis (acute)



Chapter 1: Infectious and Parasitic Diseases

- Chlamydial diseases:
 - 099.50: Chlamydial infection unspecified site
 - 099.52: Chlamydial infection anus/rectum
 - 099.53: Chlamydial infection lower GU sites
 - 099.54: Chlamydial infection other GU sites
 - Use an additional code to specify site of infection
 - PID: 614.9



Chapter 3: Endocrine, Nutritional and Metabolic Diseases

- **Obesity:**
 - **Must use** additional code to identify BMI (V85) with these codes
 - 278.00: Obesity NOS
 - 278.01: Morbid obesity
 - 278.02: Overweight



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders

- Depression:
 - Excludes: Acute stress reaction, brief depressive reaction
 - 311: Depression NOS
- Anxiety:
 - 300.00: Anxiety state
 - 300.01: Panic disorder without agoraphobia
 - 300.02: Generalized anxiety



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders

- Tobacco Use:
 - Excludes: History of use, smoking complicating pregnancy
 - 305.1: Tobacco use disorder
- Cannabis Use:
 - 305.20: Nondependent cannabis abuse, unspecified
 - 305.21: Nondependent cannabis abuse, continuous
 - 305.22: Nondependent cannabis abuse, episodic
 - 305.23: Nondependent cannabis abuse, in remission



Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium

- **When a patient is pregnant, codes from chapter 11 (630-679) are required and take priority over other codes as far as sequencing.**
- **Supervision V codes are assigned in place of chapter 11 codes when the pregnancy is incidental to the encounter.**
- **All conditions in pregnancy are assumed to be complications of pregnancy unless otherwise stated by the provider and codes from Chapter 11 are required.**



Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium

- **Episode of care is built into all conditions coded in this chapter.**
 - **Example:**
 - **Tobacco use disorder in pregnancy:**
 - 649.00: Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
 - 649.01: Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
 - 649.02: Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
 - 649.03: Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
 - 649.04: Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication



Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium

- **Obesity complicating pregnancy:**
 - 649.10: Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
 - 649.11: Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
 - 649.12: Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
 - 649.13: Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
 - 649.14: Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication



Chapter 16: Symptoms, Signs, and Ill-Defined Conditions

- **Abnormal Pap Smear**

- 795.00: Abnormal glandular Papanicolaou smear of cervix
- 795.01: Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
- 795.03: Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LGSIL)
- 795.05: Cervical high risk human papillomavirus (HPV) DNA test positive
- 795.06: Papanicolaou smear of cervix with cytologic evidence of malignancy
- 797.07: Satisfactory cervical smear but lacking transformation zone



Chapter 16: Symptoms, Signs, and Ill-Defined Conditions

- **Positive HPV**

- High risk vs. Low risk
- Must use additional code for associated HPV (079.4)
 - 795.05: Cervical high risk human papillomavirus (HPV) DNA test positive
 - 795.15: Vaginal high risk human papillomavirus (HPV) DNA test positive
 - 795.09: Cervical low risk human papillomavirus (HPV) DNA test positive
 - 795.19: Vaginal low risk human papillomavirus (HPV) DNA test positive



“V” Codes

- Can be used either as a first listed (primary) or contributing (secondary) code depending on the situation
 - Example: Patient presents for pap with a history of abnormal pap due to cervical dysplasia
 - **V13.22 – Personal history of cervical dysplasia**



“V” Codes

- Routine Examinations

ICD-9

- V70.0: Routine general medical examination at a health care facility

ICD-9

- V72.31: Routine gynecological examination



“V” Codes

- **Initial Contraceptive Management**
 - V25.01: Encounter for initial prescription of contraceptive pills
 - V25.03: Encounter for prescription of emergency contraception
 - V25.02: Encounter for initiation of other contraceptives (diaphragm, depo)
 - V25.04: Counseling and instruction in natural family planning to avoid pregnancy
 - V25.09: Other family planning advice



“V” Codes

- **Surveillance of Contraceptives**

- V25.41: Encounter for surveillance of contraceptive pills
- V25.49: Encounter for surveillance of injectable contraceptive
- V25.42: Encounter for routine checking of intrauterine contraceptive device
- V25.43: Encounter for routine checking of implantable subdermal contraceptive



“V” Codes

- **Contraceptives – Insertion/Removal/Reinsertion**
 - V25.11: Encounter for insertion of IUD
 - V25.12: Encounter for removal of IUD
 - V25.13: Encounter for removal and insertion of IUD
 - V25.5: Insertion of implantable subdermal contraceptive



“V” Codes

- **Counseling**

- V65.5: Person with feared health complaint in whom no diagnosis is made
 - “Worried Well”
- V65.3: Dietary counseling and surveillance
 - Code first any underlying medical conditions
 - Use additional code to identify BMI
- V65.41: Exercise counseling
- V65.44: Human immunodeficiency virus [HIV] counseling



“V” Codes

- **BMI:**
 - V85 Code series
 - Code selection based on age (adult/pediatric), KG, and percentiles based on CDC growth charts
 - Codes from this series are required when coding obesity or other dietary/exercise related conditions
 - **V85.41: Body mass index (BMI) 40.0-44.9, adult**
 - **V85.53: Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age**



“V” Codes

- **Problems related to lifestyle:**
 - V69.8: Self-damaging behavior
 - V69.0: Lack of physical exercise
 - V69.1: Inappropriate diet and eating habits
- **High Risk Sexual Behavior:**
 - V69.2: High risk sexual behavior



“V” Codes

- **HPV Screening**
 - V73.81: Encounter for screening for HPV
- **HIV Screening**
 - V73.89: Encounter for screening for human immunodeficiency virus [HIV]
- **Chlamydia Screening**
 - V73.88: Other specified chlamydial diseases



“V” Codes

- **Pregnancy Test Confirmation**

- V72.40: Encounter for pregnancy test, result unknown
- V72.42: Encounter for pregnancy test, result positive
- V72.41: Encounter for pregnancy test, result negative



“V” Codes

- **Supervision of pregnancy**
 - V22.0: Supervision of normal first pregnancy
 - V22.1: Supervision of other normal pregnancy
 - V22.2: Pregnant state, NOS



“V” Codes

- **Supervision of high-risk pregnancy**
 - V23.0: Supervision of pregnancy with history of infertility
 - V23.1: Supervision of pregnancy with history of trophoblastic disease
 - V23.2: Supervision of pregnancy with history of abortion
 - V23.3: Supervision of pregnancy with grand multiparity



“V” Codes

- **Supervision of high-risk pregnancy**
 - V23.41: Supervision of pregnancy with history of pre-term labor
 - V23.42: Supervision of pregnancy with history of ectopic pregnancy
 - V23.7: Supervision of pregnancy with insufficient prenatal care
 - V23.81: Supervision of pregnancy with elderly primigravida
 - V23.83: Supervision of pregnancy with history of young primigravida



“V” Codes

- **Encounter for Immunization**
 - Diagnosis code selected based on type of immunization administered
 - There are over 3 dozen ICD-9 codes for immunization encounters.
- **V04.81: Encounter for influenza immunization**
- **V06.1: Diphtheria-tetanus-pertussis, combined [DTP] [DTaP]**
- **V06.4: Measles-mumps-rubella [MMR]**



Medical Necessity

- Diagnosis codes, whether in ICD-9 or ICD-10, are used to support the **medical necessity** of **ALL** services provided. Whether an E/M, an office procedure, or a surgical procedure; the diagnosis codes(s) assigned should support the level of service(s) reported and when correctly assigned can lead to *more accurate and timely payment*.



Medical Necessity

- Overarching criterion for payment in addition to the individual requirements of a CPT code
- ICD-9 codes represent the first line of defense when it comes to medical necessity
- Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) specify the services that are allowed for certain diagnoses



Inaccurate/Incomplete Coding Example

- As with ICD-9, lack of specificity in code selection and reporting hinders statistical analysis and patient care
- Payers may target audits based on code selection, and may disable “unspecified codes” (particularly with regards to laterality) within their systems to return claims for more specific information, thus delaying claims processing
- Provider reports CPT code **58301: Removal of IUD**
- Assigns diagnosis code: **V25.9 –Unspecified contraceptive management**
- Carrier questions how the contraceptive method is unknown when billing for removal? How could the provider not know what they removed? Claim is returned for clarification, **delaying reimbursement.**



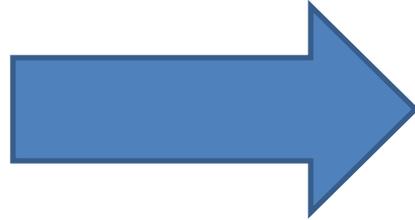
ICD-9-CM Wrap-Up

- **Code to the highest level of specificity !**
- List the principal diagnosis first, then others
- Don't code for "rule-out" or "suspect diagnoses"
- Don't code for a diagnosis that doesn't apply to the visit



Compliance Enforcement

Who are the players?



! RAC

Recovery Audit Contractors
to perform
Manual Medical Reviews

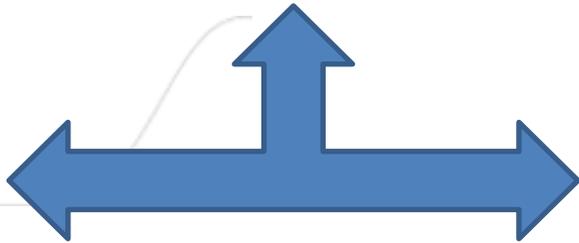
ARE YOU PREPARED?

What does
ZPICs
stand for?

Zoned Program
Integrity
Contractors



allacronyms.com



Office of
Inspector General





RAC

- Recovery Audit Contractor
- Created and mandated under the Affordable Care Act
- Mission: Deter fraud, abuse, and waste while recovering overpayments
- How: Review/Audit all provider types for inappropriate payments



RAC

- Post-payment recoupment
- Make referrals to other agencies for further investigation as appropriate (ZPIC, OIG, DOJ)
- Types of review:
 - Specific codes or services
 - Provider specific

Billing abuse is insidious; Recoupment is a shock!!!!



Why the need?

- Estimated **\$1,000,000,000,000** paid per year in fraud, waste and abuse

That's \$273,000,000 in estimated fraud EVERY DAY!

OR

\$11,375,000 PER HOUR!



HUGE CHANGE!!!

- Effective February 3, 2015 – CMS may revoke billing privileges of any provider or supplier that engages in “a pattern or practice of submitting claims that fail to meet Medicare requirements”.
- No explicit definition of “pattern or practice” – just said it meant “an error that was constant, repeated, and systematic”
 - No intent requirement
 - No warning letter



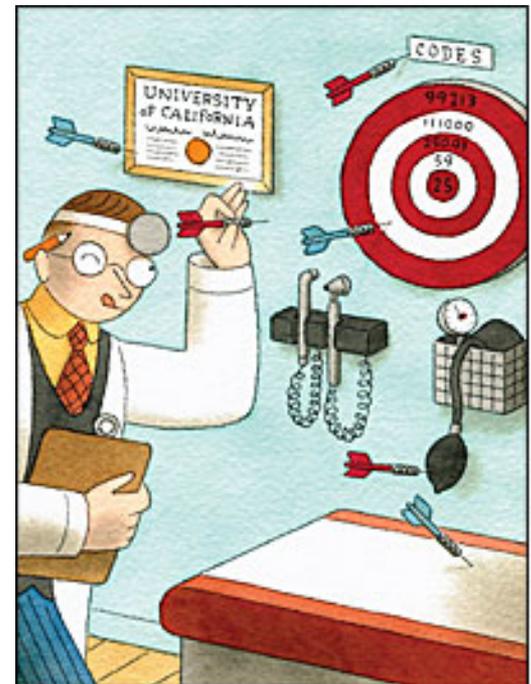
Audit Provider Documentation!!!

- Randomly select 20 Charts per provider
- Identifying:
 - Over-coding
 - Under-documenting
 - Over-documenting
 - Under-coding
 - Discrepancies
 - Opportunities to increase revenues (i.e. missing charges)





- In a public health setting, Evaluation and Management codes are the chief means of **revenue generation**.
- **E/M = Evaluation and Management** (visits)





Outpatient E/M Codes

- New Patient Codes: **99201-99205**
- Established Patient Codes: **99211-99215**



Patient Status: New or Established?

- A patient never before seen in the practice/specialty OR not seen by you or one of your partners of the same specialty in more than 3 YEARS
 - E/M codes for NEW patients
 - 99201, 99202, 99203, 99204, 99205
 - Preventative codes – 99384, 99385, 99386, 99387
- A patient who has been seen in the office by you or one of your partners of the same specialty within the last 3 YEARS.
 - E/M codes for ESTABLISHED patients
 - 99211, 99212, 99213, 99214, 99215
 - Preventative codes – 99394, 99395, 99396, 99397



New Patient

- **99201:** requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- **99202:** requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- **99203:** requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.



New Patient

- **99204:** requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- **99205:** which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.



Established Patient

- **99212:** requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- **99213:** requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.



Established Patient

- **99214:** requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
- **99215:** requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.



Evaluation and Management Services

- Requirements of E&M Documentation
- **3 Components of Documentation:**
 - **History**
 - Chief complaint; past medical, social, and family histories; ROS
 - **Exam**
 - **Medical Decision Making**
 - Number of dx or tx options; amount of data; risk



History

Subjective (patient-provided)

- Chief Complaint
- History of the present illness (HPI)
- Review of systems (ROS)
- Past, family, social history (PFSH)



Chief Complaint

- **Subjective:** Concise statement of symptoms, problems, condition, or diagnosis
- Required for all E&M services
- Should be noted whether complaint is new or established to rendering provider; this factors into calculating the level of service.



Chief Complaint

Poor example:

“Patient here for follow up”

Good example:

“Patient presents to discuss birth control methods.”

“Patient follows up for irregular bleeding post IUD insertion.”



History of Present Illness (HPI)

- Chronological description of the development of the patient's presenting problem from the first sign and symptom, or from the previous visit to the current visit
 - In regards to elements as per coding tool, all must relate to one 'chief complaint'
- Must be personally performed by the provider
- Extent of HPI performed is based on provider's professional judgment depending on the needs of the patient



History of Present Illness (HPI)

- ▶ **LOCATION:** Where, site of the symptoms
- ▶ **QUALITY:** Sharp, stabbing, radiating, dull, etc.
- ▶ **DURATION:** How long have the symptoms existed
- ▶ **SEVERITY:** Pain Scale
- ▶ **TIMING:** Relationship to something else (upon waking up or after eating)
- ▶ **MODIFYING FACTORS:** Influence symptoms
- ▶ **CONTEXT:** When does the symptom occur
- ▶ **ASSOCIATED SIGNS AND SYMPTOMS:** Symptoms that accompany complaint



History of Present Illness (HPI)

Patient had an IUD placed a few weeks ago and now presents with vaginal pain at the insertion site x1 week. Patient describes the pain as sharp. Patient reports associated cramping.

- Location:** vaginal pain
- Duration:** 1 week
- Quality:** pain is sharp
- Associated signs and symptoms:** cramping



Review of Systems

- **Subjective** : Verbal inventory of body systems obtained through a series of questions with the patient related to the presenting problem. Should include pertinent positives and negatives.
- May be obtained by the nurse, doctor, history form, or other ancillary staff
- Provider must review and corroborate the information if obtained by another source and document this review and agreement for credit.



Review of Systems (ROS)

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Hematologic/lymph
- GI
- GU
- Musculoskeletal
- Integumentary/breast
- Allergic/Immunologic
- Neurologic
- Psychiatric
- Endocrine



Review of Systems

- A complete review of systems includes checking at least **10** separate systems.
- The statement, “all remaining 10 point review of systems are negative, except as noted in the HPI” is acceptable documentation.
- ROS do not have to be broken out individually by system to receive credit.
- If ROS is unobtainable – document such cases, as comprehensive (10 systems) credit will be given.



Review of Systems (ROS)

Bad example:

“Negative review”

Good example:

“Eyes — no blurred vision”

“Neuro — no headaches”

“GI — no diarrhea or constipation”

“Respiratory — no shortness of breath”



Review of Systems (ROS)

Good example:

ROS: Positive for fatigue and changes in bowel habits. Remaining 10 point ROS is otherwise negative except as noted in the HPI.



Past Medical, Family, & Social **Histories**

- 3rd element of the 'History' section
- The needs of the patient determine the complexity of documenting PFSH
- Should be age and gender appropriate and relevant to patient presentation



Past History

- Prior major illnesses or injuries
- Operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/dietary status



Family History

- **A review of medical events in the patient's family that could be significant to the patient**
- Health status or cause of death of parents, siblings, or children (blood relatives)
- Specific diseases related to problems identified in the chief complaint, HPI or ROS
- Hereditary disease putting the patient at risk



Social History

Age appropriate review of past and current activities including:

- Marital status
- Employment
- Occupational history
- Use of drugs, alcohol & tobacco
- Level of education
- Sexual history
- Exercise habits
- Other social factors



Past Medical, Family, & Social Histories

Bad example:

“Reviewed unchanged.”

Good example:

Patient has a past medical history positive for appendectomy. Patient denies tobacco or alcohol use. Family history positive for heart disease in mother.



Past Medical, Family, & Social Histories

**Problem Pertinent = Reviewing 1 area of
past/family/social hx**

**Complete Review for New Patient = Reviewing
ALL 3 areas of past/family/social hx**

**Complete Review for Established Patient =
Reviewing 2 areas of past/family/social hx**



History

4 Levels of History

- Problem Focused
 - Requires 1-3 elements
- Expanded Problem-Focused
 - Requires 1-3 elements or status of 1-2 chronic conditions
 - Requires at least one review of system
- Detailed
 - Requires 4 elements or status of 3 chronic conditions
 - Requires 2-9 review of systems
 - Requires at least one area of history (past/family/social)
- Comprehensive
 - Requires 4 elements or status of 3 chronic conditions
 - Requires 10 review of systems
 - Requires all 3 areas of history (past/family/social)



History

- Expanded Problem-Focused for 99202, 99213
 - Requires 1-3 elements or status of 1-2 chronic conditions
 - Requires at least one review of system
- Detailed for 99203 and 99214
 - Requires 4 elements or 3 Chronic Conditions
 - Requires 2-9 review of systems
 - Requires at least one area of history (past/family/social)
- Comprehensive for 99204, 99205 and 99215
 - Requires 4 elements or 3 Chronic Conditions
 - Requires 10 review of systems
 - Requires all areas of history (past/family/social)



History

HISTORY	HPI: Status of chronic conditions: <input type="checkbox"/> 1 condition <input type="checkbox"/> 2 conditions <input type="checkbox"/> 3 conditions <p style="text-align: center;">OR</p> HPI (history of present illness) elements: <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Associated signs and symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	ROS (review of systems): <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Eyes <input type="checkbox"/> Ears,nose, mouth, throat <input type="checkbox"/> Card/vasc <input type="checkbox"/> Resp <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musculo <input type="checkbox"/> Integumentary (skin, breast) <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endo <input type="checkbox"/> Hem/lymph <input type="checkbox"/> All/immuno <input type="checkbox"/> All others negative	<input type="checkbox"/>				
	PFSH (past medical, family, social history) areas: <input type="checkbox"/> Past history (the patient's past experiences with illnesses, operation, injuries and treatments) <input type="checkbox"/> Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) <input type="checkbox"/> Social history (an age appropriate review of past and current activities)	<input type="checkbox"/>				
	Complete ROS: 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative".	<input type="checkbox"/>				
		PROBLEM FOCUSED	EXP.PROB. FOCUSED	DETAILED	COMPRE-HENSIVE	



History Example

What level of history does this documentation support?

- **HPI:**

Patient had an IUD placed a few weeks ago and now presents with vaginal pain at the insertion site x1 week. Patient describes the pain as sharp. Patient reports associated cramping.

- **ROS:** A 10-point review of systems negative other than that in HPI.
- **PAST SURGICAL HISTORY:** Tonsillectomy
- **SOCIAL HISTORY:** Denies any exposure to tobacco.
- **FAMILY HISTORY:** Unknown. Patient adopted.



History Example

What level of history does this documentation support?

- **HPI**
 - **4 HPI Elements**
- **10+ ROS**
- **3 areas of history documented**
 - *Comprehensive History***



Examination

- **Objective:** information the provider gathers
- Observations of the provider during the encounter
- Exam includes findings by body area or organ system
- Assessment of the patient's general appearance, vital signs, or level of distress
- There should ALWAYS be an exam of the affected body area(s) and/or system(s)



Exam: 2 Sets of Acceptable Guidelines

1995



1997



Exam: 2 Sets of Acceptable Guidelines

1995-

- Used for counting body area(s) vs. organ system(s)

1997-

- Used for counting bulleted elements for each body area(s) or organ system(s)



Body Areas vs. Organ Systems

- **Body Areas:** Head, back, chest, genitalia, abdomen, neck, each extremity
- **Organ Systems:**
 - Constitutional (vitals)
 - Eyes
 - ENT
 - Respiratory
 - GI
 - GU
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Lymphatic

Cannot COMBINE body areas and organ systems for calculation of level of physical exam



Examination

4 Types of Examination based on 1995 Guidelines:

- **Problem Focused** - a limited examination of the affected body area or organ system.
- **Expanded Problem-Focused** – a limited examination of the affected body area or organ system and any symptomatic or related body area(s) or organ system(s). Minimum 2 body areas/organ systems examined.
- **Detailed** – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s). Minimum 4 body areas/organ systems examined with depth in one area/system.
- **Comprehensive** – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s). Minimum 8 organ systems examined.



Examination

Options include:

1 x 1 = PF

2 x 1 = EPF

4 x 4 = DET

8 x 1 = COMP



Detailed Exam: Novitas Specific

4x4: Examining 4 systems with 4 statements

- **Constitutional:** well-nourished, well developed, alert, in no acute distress
- **Respiratory:** breathing unlabored, no accessory muscle use, normal breath sounds throughout, no retractions
- **Cardiovascular:** regular rate, normal rhythm, normal S1, normal S2.
- **Skin and Subcutaneous tissue:** no rashes present, no lesions present, no areas of discoloration.



Examination

- **Expanded Problem-Focused** – for 99202 or 99213
 - a limited examination of the affected body area or organ system and any symptomatic or related body area(s) or organ system(s). Minimum 2 body areas/organ systems examined.
- **Detailed** – for 99203 or 99214
 - an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s). Minimum 4 body areas/organ systems examined with depth in one area/system.
- **Comprehensive** – for 99204, 99205 or 99215
 - a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s). Minimum 8 organ systems examined.



Examination

EXAM

Body areas:

- Head, including face
- Chest, including breasts and axillae
- Abdomen
- Neck
- Back, including spine
- Genitalia, groin, buttocks
- Each extremity

Organ systems:

- Constitutional (e.g., vitals, gen app)
- Ears, nose, mouth, throat
- Cardiovascular
- Resp
- GI
- GU
- Musculo
- Skin
- Neuro
- Psych
- Hem/lymph/imm

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 body area or system	Up to 7 systems	Up to 7 systems	8 or more systems
PROBLEM FOCUSED	EXP.PROB. FOCUSED	DETAILED	COMPRE-HENSIVE



Examination

4 Types of Examination based on 1997 Guidelines:

- **Problem Focused** – should include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
- **Expanded Problem-Focused** – should include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
- **Detailed** – should include performance and documentation of at least twelve elements identified by a bullet in two or more organ system(s) or body area(s).
- **Comprehensive** – should include performance and documentation of at least eighteen elements identified by a bullet in nine or more organ system(s) or body area(s).



Examination

System/Body Area	Elements of Examination
Musculoskeletal	<ul style="list-style-type: none"> • Examination of gait and station <p>Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements <p>NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.</p>
Extremities	[See musculoskeletal and skin]
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. <p>NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.</p>



Examination

Bad example:

“HEENT – unremarkable”

“ Abdomen – WNL”

Good example:

“EENT-EOMI, tympanic membranes pearly grey,
normal oral mucosa”

“Abdomen-soft, non-tender, no organomegaly”



Examination Example

What level of exam does this documentation support?

- Blood pressure is 161/93, heart rate of 84, respiratory rate of 16, oxygen saturation 94% on 2 L, temperature is 37.2.
- WD/WN
- Pupils are equal, round and reactive to light. Conjunctivae are pink.
- Cardiovascular is regular rate and rhythm. No murmurs, rubs, or gallops.
- Lungs appear diffusely wheezy. No rhonchi or rales with abnormal breath sounds.



Examination Example

What level of exam does this documentation support?

- **General Appearance:** WD/WN, alert, no apparent distress
- **EENT:** PERRL/EOMI, pharynx normal, pharyngeal erythema, No tonsillar exudate
- **Neck:** non-tender, supple, normal inspection
- **Respiratory:** chest non-tender, lungs clear, normal breath sounds, No respiratory distress, No accessory muscle use, No decreased breath sounds, No crackles, No rhonchi, No wheezing
- **Cardiac/Chest:** normal peripheral pulses, regular rate, rhythm, edema, No tachycardia, No systolic murmur
- **Abdomen:** normal bowel sounds, non-tender, soft, No distended, No guarding, No rebound
- **Skin:** normal color, warm/dry, No cyanosis, No diaphoresis, No jaundice, No mottled
- **Extremities:** normal range of motion, non-tender, normal inspection
- **Neuro/Psych:** alert, normal mood/affect, oriented x 3



Medical Decision Making

Complexity of MDM based upon 3 elements:

1. Number of diagnoses **OR** treatment options
2. Amount and complexity of data to review/order
3. Overall level of risk of the patient



Number of Diagnoses

- Each encounter should have an **assessment**, a **clinical impression** or **diagnosis**
- For a presenting problem with an established Dx the record should reflect whether the problem is improved, resolved, stable, or worsening/inadequately controlled
- For a presenting problem without an established diagnosis, differential diagnoses are acceptable. Please note that these may not be coded in the outpatient setting, however they may be used to factor medical decision making
- Each diagnosis earns points



of Diagnoses

Number of Diagnoses or Treatment Options			
A	B	X	C = D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	<i>Max = 2</i>	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	<i>Max = 1</i>	3	
New prob. (to examiner); add. workup planned		4	
TOTAL			

Multiply the number in column B, X, C and put the product in column D.



of Diagnoses Example

New patient-

- Suspect Chlamydia – will order G/C to determine next course of action

How many points for # of diagnoses?



of Diagnoses Example

Established patient-F/U

- Chlamydia – now resolved with course of antibiotics
- Bleeding/Cramping post IUD-worsening, wants to explore other methods

How many points for # of diagnoses?



Data To Be Reviewed/Ordered

- Review/order labs, X-rays or other diagnostic tests
- Independent visualization should be clearly differentiated from 'review' alone.
 - Personally visualized/interpreted
 - Independently interpreted/reviewed
- Relevant findings from the review of old records should be included. If nothing new comes from record review, it should be documented
- Document discussion of case with other providers



Data To Be Reviewed/Ordered

- Amount and/or Complexity of Data to be Reviewed
 - 1 point is assigned for:
 - Review and/or order clinical lab tests (80000 code series)
 - Review and/or tests in CPT radiology section (70000 code series)
 - Review and/or tests in CPT medicine section (90000 code series)
 - Decision to obtain old records
 - 2 points is assigned for:
 - Independent interpretation of image, tracing or specimen itself (not simply review of report)
 - Discussion of case with other providers
 - Review and summarization of old records



Data To Be Reviewed/Ordered

Amount and/or Complexity of Data Reviewed	
Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	



Data Example

- Provider reviews:
 - Labs – UA w/ micro
- Provider orders:
 - G/C and HIV

How many points for data?



Level of Risk

This part of medical decision making deals with the guidelines for determining risk of significant complications, morbidity or mortality

- Level of risk is determined by where the patient falls highest in the following categories: presenting problems, diagnostic procedures ordered, and management options selected

The table of risk may be used as a guide



Level of Risk

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

MEDICAL DECISION

Risk of Complications and/or Morbidity or Mortality

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g., echo KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic with identified risk factors) Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis



Medical Decision Making

The extent to which each element of decision making is considered determines the overall level of complexity of decision making:

Straightforward:

– 1 point in # of diagnoses, no data review, minimal risk

Low Complexity:

– 2 points in # of diagnoses, 2 points in data reviewed, low risk

Moderate Complexity:

– 3 points in # of diagnoses, 3 points in data reviewed, moderate risk

High Complexity:

– 4 points in # of diagnoses, 4 points in data reviewed, high risk

Two of the three MDM components must be met to achieve level of complexity.



The highest in 2/3 categories determines final complexity

making them the appropriate grid in section 6.

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.



MDM Example

– New Patient:

- Patient is newly sexually active and would like to try birth control pills.
- Provider orders pregnancy test and STI panel, which came back negative.
- Prescribed OCPs.

What level of MDM does this correlate with?



Calculating Level of Service

See E/M Coding Calculator



Calculating Level of Service

- New Patient services require 3/3 components (history, exam, MDM).
- **Example:** Patient was seen and the provider documented a detailed history, a comprehensive physical examination, and moderate complexity medical decision making.

What is the correct E/M code?



Calculating Level of Service

- New Patient services require 3/3 components (history, exam, MDM).
- **Example:** Patient was seen and the provider documented a detailed history, an expanded problem focused physical examination, and low complexity medical decision making.

What is the correct E/M code?



Calculating Level of Service

- New Patient services require 3/3 components (history, exam, MDM).
- **Example:** Patient was seen and the provider documented a comprehensive history, a comprehensive physical examination, and moderate complexity medical decision making.

What is the correct E/M code?



Calculating Level of Service

- Established patient services require 2/3 components (history, exam, MDM) with one being medical-decision-making.
- **Example:** Patient returning for follow-up. Provider documented an expanded-problem focused history, a detailed physical examination, and moderate complexity medical decision making.

What is the correct E/M code?



Calculating Level of Service

- Established patient services require 2/3 components (history, exam, MDM) with one being medical-decision-making.
- **Example:** Patient returning for follow-up. Provider documented a problem focused history, a expanded problem focused physical examination, and low complexity medical decision making.

What is the correct E/M code?



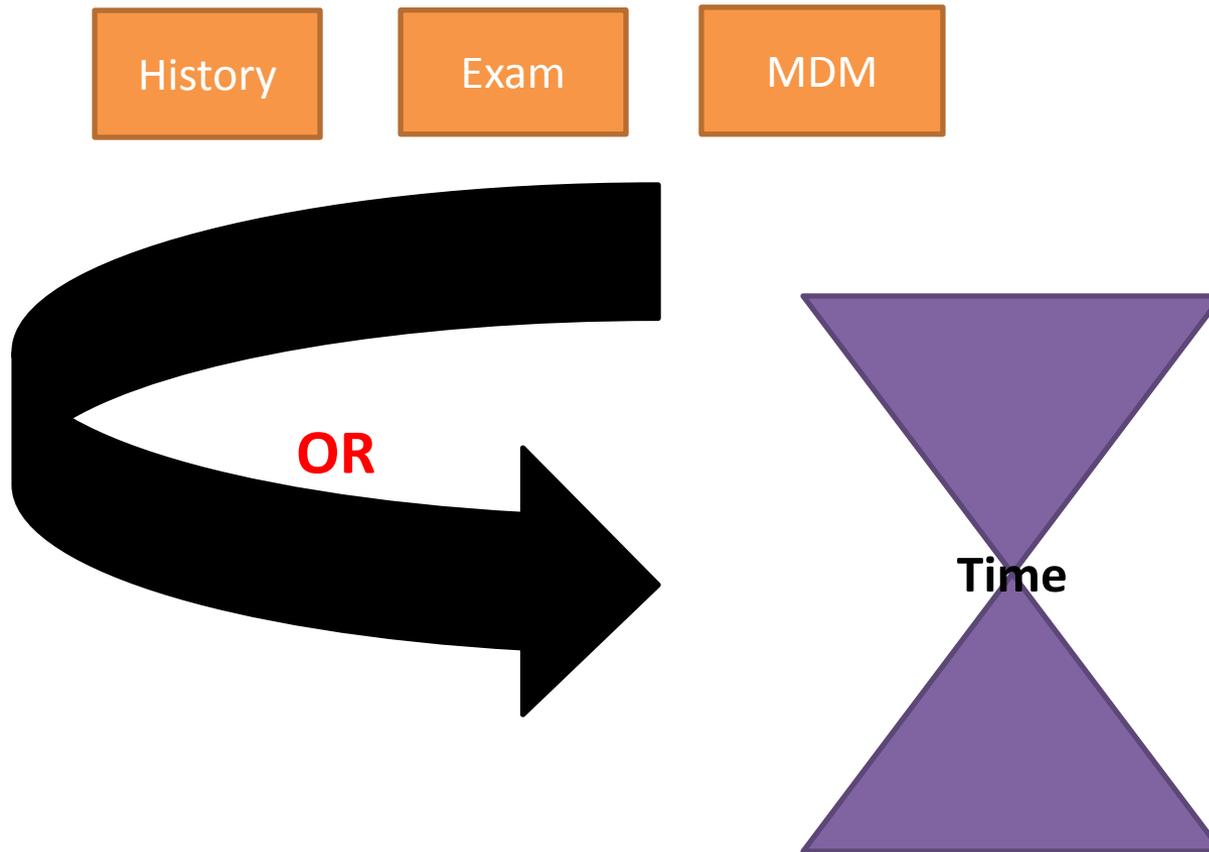
Calculating Level of Service

- Established patient services require 2/3 components (history, exam, MDM) with one being medical-decision-making.
- **Example:** Patient returning for follow-up. Provider documented a detailed history, an expanded problem focused physical examination, and straight-forward complexity medical decision making.

What is the correct E/M code?



Time-Based Coding





Time-Based Coding

- Time, **when documented appropriately**, can increase the level of service billed based on time spent counseling and coordinating the patient's care
- Time based coding should only be used in those unique circumstances for which counseling and/or coordination of care dominates and drives the visit.
- Documentation requirements include: total duration of the visit, time spent in counseling and/or coordination of patient care, and the content of the counseling or care coordination. The time spent in counseling or care coordination must constitute greater than 50% of the total visit.



Time-Based Coding

Documentation requirements include:

- total duration of the face-to-face visit,
- time spent in counseling and/or coordination of patient care,
- the content of the counseling or care coordination.
- The time spent in counseling or care coordination must constitute greater than 50% of the total visit.



Time-Based Coding

99201 = 10 minutes

99202 = 20 minutes

99203 = 30 minutes

99204 = 45 minutes

99205 = 60 minutes



Time-Based Coding

99211 = 5 minutes

99212 = 10 minutes

99213 = 15 minutes

99214 = 25 minutes

99215 = 40 minutes



Time-Based Coding

Example: 45 minutes spent face-to-face with this new patient; the whole visit spent counseling her on various birth control methods and issues encountered with previously using the pill.

What level of service does this documentation support based on time?



Time-Based Coding

Example: 25 minutes spent face-to-face with this established patient, 15 minutes of which was spent counseling her on depression following the depo shot. Discussed the need for new form of BC.

What level of service does this documentation support based on time?



We're going through changes...



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Why the Change to ICD-10-CM?

- The new structure allows for further expansion than the current ICD-9 system; allowing clinical advances to be incorporated more readily
- ICD-10 is used in all other industrialized countries, and is better suited to capture morbidity and mortality data; allows for international data collection
- Need for more specificity in the reporting of diseases and recently recognized conditions
- Much of additional clinical detail was recommended by physician groups
- The greater detail and granularity allows greater capability to measure quality outcomes, which is the future of payment methodology



It's Happening.....

The ICD-10-CM/PCS final rule requires HIPAA *covered entities* to adopt the code sets by October 1, 2015.

Adoption is not required for non-covered entities such as:

- Work comp and auto
- Property and casualty insurance health plans
- Disability insurance programs
- Many do have plans to implement ICD-10, but you will have to find out which system they will use.

People, processes and systems must accommodate both!!

ICD-9 will no longer be maintained once ICD-10 is implemented. The final ICD-9 update was 2012.



What ICD-10 Means to Providers

ICD-10-CM:

Unspecified = I
don't know!

ALL About the
SPECIFICITY!

ICD-9:
Unspecified =
I don't care!



Resources & References

2015 ICD-10-CM is available at

<http://www.cdc.gov/nchs/icd/icd10cm.htm> or
<http://www.cms.hhs.gov/ICD10>

- **2015 ICD-10-CM Index to Diseases and Injuries**
- **2015 ICD-10-CM Tabular List of Diseases and Injuries**
 - Instructional Notations
- 2015 Official Guidelines for Coding and Reporting
- 2015 Table of Drugs and Chemicals
- 2015 Neoplasm Table
- 2015 Index to External Causes



GEMs

- CMS and the CDC developed General Equivalency Mapping to ensure that consistency in national data is maintained.
- They made a commitment to update these annually along with the annual ICD-10 updates for the transition period prior to ICD-10 implementation and for 3 years beyond implementation.





GEMs

- While GEMs are a useful tool; due to concept additions in ICD-10, GEMs forward maps are not all encompassing and should not solely be relied upon for diagnosis code conversion.
 - Example: ICD-9 code V72.31 for routine GYN exam would map to unspecified exam in ICD-10 as the new concept of with/without abnormal findings now exists in ICD-10, whereas it was not a concept in ICD-9.



ICD-10-CM

CODING CONVENTIONS AND STRUCTURE



Code Structure ICD-10-CM

ICD-10-CM

3-7 characters

First character is always alpha

All letters used except U

Character 2 always numeric

Characters 3 through 7 can be alpha or numeric

Always at least 3 characters

Approximately 68,000 codes versus approximately 13,000 ICD-9 diagnosis codes

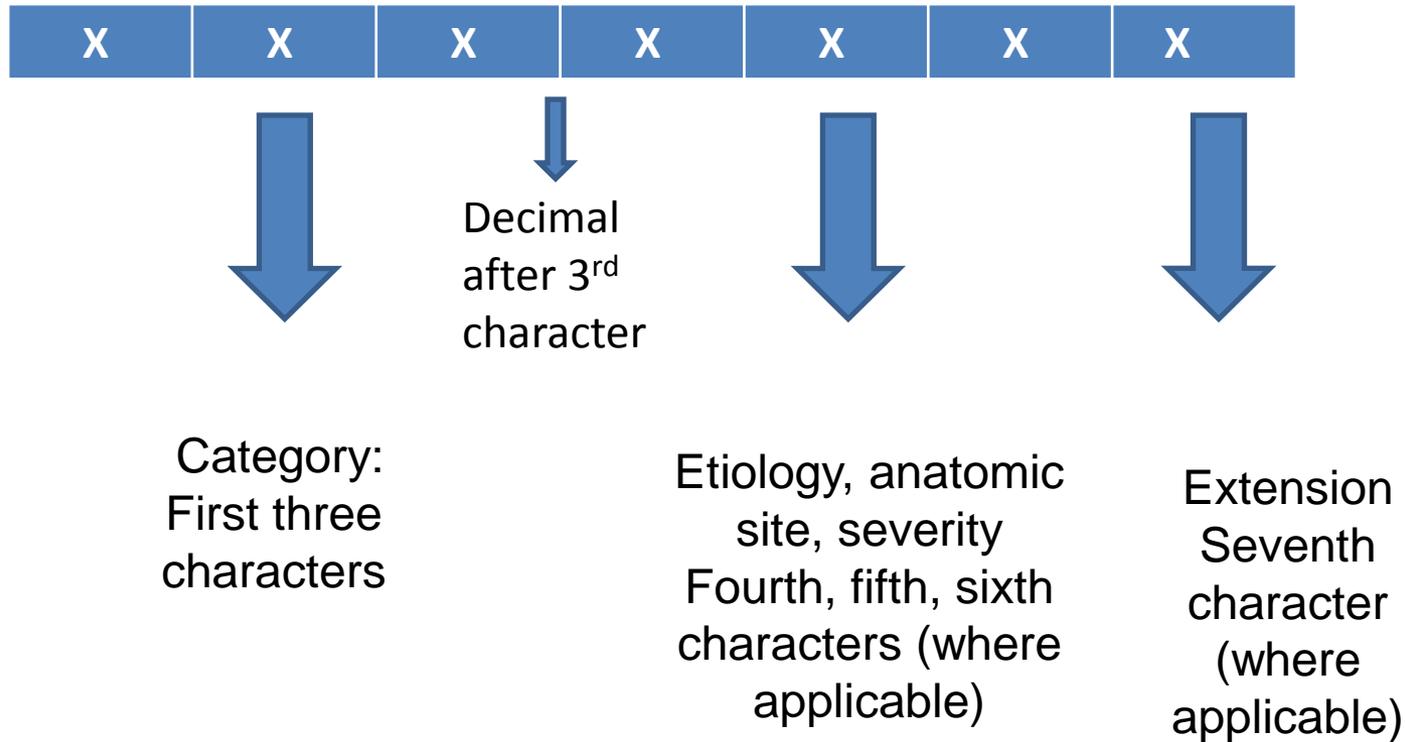
Use of decimal after 3 characters

Alpha characters are not case-sensitive

Each code description is completely defined; no need to refer to the category/subcategory for reference



Code Structure ICD-10-CM





ICD-10-CM Convention Additions

- **Excludes 1** notes to indicate when the code can't be used with another code. Used when a condition cannot occur together, such as a congenital form of a condition with an acquired form of the same condition (NOT CODED HERE)
- **Excludes 2** notes to indicate that the condition excluded is not part of the condition represented by the code, but that the patient may have both conditions at the same time.

Think about it: this information will not be available in your EMR



ICD-10-CM Conventions

- **Includes notes**
 - Appear immediately under a three character category title to further define, or give examples of, the content of the category.
- **Inclusion terms**
 - List of terms included under some codes that reflect conditions for which that code is to be used. The inclusion terms are not necessary exhaustive.



Overview of ICD-10-CM Changes

- **21 Chapters in ICD-10-CM** compared to 17 Chapters in ICD-9-CM
- The majority of supplemental V and E codes in ICD-9 are incorporated into the main classification in ICD-10
- Diseases and condition of eyes and ears (which were included in the nervous system section in ICD-9) have their own chapters in ICD-10
- Certain diseases reclassified in more appropriate chapters, for example, gout reassigned from endocrine to musculoskeletal



One-to-One?

- ICD-9-CM code – Apple



- ICD-10-CM codes:





Inaccurate/Incomplete Coding Example

- Provider reports CPT code ***58301: Removal of IUD***
- Assigns diagnosis code: ***Z30.9 – Encounter for contraceptive management, unspecified***
- Carrier questions how the contraceptive method is unknown when billing for removal? How could the provider not know what they removed? Claim is returned for clarification, ***delaying reimbursement.***



Chapter-specific concept additions that may affect the way you document



**KEEP
CALM
AND
CODE
ON**



ICD-10-CM: Diagnosis Coding for FP, PE, and IMM

- ICD-10-CM codes for your most frequently utilized codes are found in the following chapters:
 - **Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)**
 - **Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F00-F99)**
 - **Chapter 14: Diseases of the Genitourinary System (N00-N99)**
 - **Chapter 15: Pregnancy, Childbirth and the Puerperium (O00-O9A)**
 - **Chapter 18: Symptoms, Signs and Abnormal Clinical/Laboratory Findings (R00-R99)**
 - **Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)**



Chapter 1: Infectious and Parasitic Diseases (A00-B99)

- **Changes:**
 - Includes new section called infections with a predominantly sexual mode of transmission (A50-A64).
 - Code first condition resulting from (sequela) the infectious or parasitic disease.



Chapter 1: Infectious and Parasitic Diseases (A00-B99)

- Viral warts and Venereal warts are now classified in 2 separate sections of Chapter 1
- Viral Warts due to human papilloma virus
 - Plantar wart = B07.0
 - Other viral warts = B07.8
 - Viral warts, unspecified = B07.9
- Venereal Warts due to human papilloma virus
 - Anogenital = A63.0



Chapter 1: Infectious and Parasitic Diseases (A00-B99)

- HPV
 - B97.7: Papillomavirus
- Syphilis
 - A53.9: Syphilis NOS
 - A53.0: Latent syphilis
- Herpes Simplex
 - B00.9: Herpes Simplex Infection



Chapter 1: Infectious and Parasitic Diseases (A00-B99)

- Gonococcal infections:
 - **A54.00:** Gonococcal infection of lower genitourinary tract, unspecified
 - **A54.01:** Gonococcal cystitis and urethritis, unspecified
 - **A54.22:** Gonococcal prostatitis
 - **A54.24:** Gonococcal female pelvic inflammatory disease



Chapter 1: Infectious and Parasitic Diseases (A00-B99)

- Chlamydial diseases:
 - **A56.00:** Chlamydial infection of lower genitourinary tract, unspecified
 - **A56.02:** Chlamydial vulvovaginitis
 - **A56.11:** Chlamydial female pelvic inflammatory disease
 - **A56.3:** Chlamydial infection of anus and rectum



Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

- Obesity:
 - Now distinguishes cause of obesity
 - **Must use** additional code to identify BMI (Z68) with these codes
 - E66.01: Morbid (severe) obesity due to excess calories
 - E66.09: Other obesity due to excess calories
 - E66.1: Drug-induced obesity
 - E66.2: Other obesity
 - E66.3: Overweight



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F00-F99)

- Depression:
 - Excludes: Bipolar disorder, manic episodes, recurrent depressive disorder
 - F32.0: Major depressive disorder, single episode, mild
 - F32.1: Major depressive disorder, single episode, moderate
 - F32.2: Major depressive disorder, single episode, severe without psychotic features
 - F32.3: Major depressive disorder, single episode, severe with psychotic features
 - F32.4: Major depressive disorder, single episode, in partial remission
 - F32.5: Major depressive disorder, single episode, in full remission



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F00-F99)

- Anxiety:
 - F41.0: Panic disorder [episodic paroxysmal anxiety] without agoraphobia
 - F41.1: Generalized anxiety disorder
 - F41.3: Other mixed anxiety disorders
 - F41.8: Other specified anxiety disorders
 - Anxiety with depression
 - F41.9: Anxiety disorder, unspecified



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F00-F99)

- Alcohol:
 - Classified by abuse, dependence, use and by associated complications
 - F10.120: Alcohol abuse with intoxication, uncomplicated
 - F10.151: Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
 - F10.21: Alcohol dependence, in remission
 - F10.221: Alcohol dependence with intoxication delirium
 - F10.280: Alcohol dependence with alcohol-induced anxiety disorder
 - F10.950: Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions



Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F00-F99)

- Tobacco Use:
 - Excludes: History of dependence and current use
 - Classified by type of nicotine (cigarettes, chewing) and status
 - F17.210: Nicotine dependence, cigarettes, uncomplicated
 - F17.211: Nicotine dependence, cigarettes, in remission
 - F17.213: Nicotine dependence, cigarettes, with withdrawal
 - F17.218: Nicotine dependence, cigarettes, with other nicotine-induced disorders
 - F17.223: Nicotine dependence, chewing tobacco, with withdrawal
 - F17.291: Nicotine dependence, other tobacco product, in remission



Chapter 14: Diseases of the Genitourinary System (N00-N99)

- UTI:
 - N39.0: Urinary tract infection, site not specified
 - Use an additional code to identify infectious agent (B95-B97)
- Site specific options exist for:
 - Cystitis
 - Urethritis



Chapter 15: Pregnancy, Childbirth and the Puerperium,

New Features:

- **The episode of care**, which is designated in ICD-9 (antepartum, delivered, postpartum) **is no longer a primary classification in ICD-10.**
- Now (ICD-10) the majority of obstetric codes have a **final character that identifies the trimester of pregnancy**, which also includes a character for unspecified trimester.



ICD-9-CM	ICD-10-CM
V23.2 – Supervision of high-risk pregnancy; Pregnancy with history of abortion	<p>O09.291 - Supervision of pregnancy with other poor reproductive or obstetric history, first trimester</p> <p>O09.292- Supervision of pregnancy with other poor reproductive or obstetric history, second trimester</p> <p>O09.293 - Supervision of pregnancy with other poor reproductive or obstetric history, third trimester</p> <p>O09.299 – Supervision of pregnancy with other poor reproductive or obstetric history, unspecified trimester</p>
649.03 – Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	<p>O99.331 – Smoking (tobacco) complicating pregnancy, first trimester</p> <p>O99.332 - Smoking (tobacco) complicating pregnancy, second trimester</p> <p>O99.333 - Smoking (tobacco) complicating pregnancy, third trimester</p>



Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

- This chapter contains the following blocks:
 - R00-R09: Symptoms and signs involving the circulatory and respiratory systems
 - R10-R19: Symptoms and signs involving the digestive system and abdomen
 - R20-R23: Symptoms and signs involving the skin and subcutaneous tissue
 - R25-R29: Symptoms and signs involving the nervous and musculoskeletal systems
 - R30-R39: Symptoms and signs involving the genitourinary system
 - R40-R46: Symptoms and signs involving cognition, perception, emotional state, and behavior
 - R47-R49: Symptoms and signs involving speech and voice
 - R50-R69: General symptoms and signs
 - R70-R79: Abnormal findings on examination of blood, without diagnosis
 - R80-R82: Abnormal findings on examination of urine, without diagnosis
 - R83-R89: Abnormal findings on examination of other bodily fluids, substances and tissues, without diagnosis
 - R90-R94: Abnormal findings on diagnostic imaging and in function studies, without diagnosis
 - R97: Abnormal tumor markers
 - R99: Ill-defined and unknown cause of mortality



Chapter 18

Codes Used for:

a

- No more specific diagnosis can be made even after all facts have been investigated

b

- Signs or symptoms existing at time of initial encounter - transient and causes not determined

c

- Provisional diagnosis in patient failing to return

d

- Referred elsewhere before diagnosis made

e

- More precise diagnosis not available

f

- Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right



Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

- **Abdominal Pain**

- R10.0: Acute abdomen
 - Inc. Severe abdominal pain (generalized) (with abdominal rigidity)
- R10.10: Upper abdominal pain, unspecified
- R10.11: Right upper quadrant pain
- R10.12: Left upper quadrant pain
- R10.13: Epigastric pain
 - Inc. Dyspepsia
- R10.2: Pelvic and perineal pain
- R10.30: Lower abdominal pain, unspecified
- R10.31: Right lower quadrant pain
- R10.32: Left lower quadrant pain
- R10.33: Periumbilical pain
- R10.84: Generalized abdominal pain
- **R10.9: Unspecified abdominal pain**



Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

- **Abnormal Pap Smear**

- R87.619: Unspecified abnormal cytological findings in specimens from cervix uteri
- R87.610 : Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
- R87.611: Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of cervix (ASC-H)
- R87.612: Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
- R87.613: High grade squamous intraepithelial lesion on cytologic smear of cervix (HGSIL)
- R87.614: Cytologic evidence of malignancy on smear of cervix
- R87.618: Other abnormal cytological findings on specimens from cervix uteri



Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

- **Positive HPV**

- High risk vs. Low risk

- Must use additional code for associated HPV (B97.7)

- R87.810: Cervical high risk human papillomavirus (HPV) DNA test positive
- R87.811: Vaginal high risk human papillomavirus (HPV) DNA test positive
- R87.820: Cervical low risk human papillomavirus (HPV) DNA test positive
- R87.821: Vaginal low risk human papillomavirus (HPV) DNA test positive



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

This chapter contains the following blocks:

- Z00-Z13: Persons encountering health services for examinations
- Z14-Z15: Genetic carrier and genetic susceptibility to disease
- Z16: Resistance to antimicrobial drugs
- Z17: Estrogen receptor status
- Z18: Retained foreign body fragments
- Z20-Z28: Persons with potential health hazards related to communicable diseases
- Z30-Z39: Persons encountering health services in circumstances related to reproduction

- Z40-Z53: Encounters for other specific health care
- Z55-Z65: Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- Z66: Do not resuscitate status
- Z67: Blood type
- Z68: Body mass index (BMI)
- Z69-Z76: Persons encountering health services in other circumstances
- Z77-Z99: Persons with potential health hazards related to family and personal history and certain conditions influencing health status



Chapter 21 Guidelines

- Z codes are the new V codes.
- Z codes are for use in any healthcare setting and may be used as either a first listed (principal diagnosis in the inpatient setting) or secondary code, depending on the circumstances of the encounter.



Chapter 21 Guidelines

- Screening
 - The testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease.
- The testing of a person to rule out/confirm a suspected diagnosis because the patient has some sign/symptom is a diagnostic examination, not a screening.
- A screening code may be used as the first listed code if the reason for the visit is specifically for the screening exam.
- A screening code may also be used as an additional code if the screening is done during an office visit for other health problems.
- Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.



Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)

New Features

Extensive expansion of codes for circumstances relating to social, economic and psychosocial circumstances that may present potential health hazards. Occupational exposures, problems related to upbringing, stressors, etc. Some may be necessary for reimbursement.

- Extreme poverty
- Low income
- Removal from home in childhood
- Problems in relationship with in-laws
- Unemployment
- Work stressors (very specific now; threat of job loss, change of job, uncongenial work environment, etc.)
- Blood alcohol level
- DNR status

****Think about it: Medical necessity for E/M visits dominated by counseling****



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- Routine Examinations

ICD-9

- V70.0: Routine general medical examination at a health care facility

ICD-10

- Z00.00: Encounter for general adult medical examination without abnormal findings
- Z00.01: Encounter for general adult medical examination with abnormal findings

ICD-9

- V72.31: Routine gynecological examination

ICD-10

- Z01.411: Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419: Encounter for gynecological examination (general) (routine) without abnormal findings



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- Encounters with abnormal findings:
 - Use additional codes to reflect the abnormal findings, when present.
 - Established chronic conditions should not be considered “abnormal findings” unless a change in their status has occurred.



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Initial Contraceptive Management**
 - Z30.011: Encounter for initial prescription of contraceptive pills
 - Z30.012: Encounter for prescription of emergency contraception
 - Z30.013: Encounter for initial prescription of injectable contraceptive
 - Z30.014: Encounter for initial prescription of intrauterine contraceptive device
 - Z30.018: Encounter for initial prescription of other contraceptives
 - Z30.019: Encounter for initial prescription of contraceptives, unspecified
 - Z30.02: Counseling and instruction in natural family planning to avoid pregnancy



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Surveillance of Contraceptives**

- Z30.41: Encounter for surveillance of contraceptive pills
- Z30.42: Encounter for surveillance of injectable contraceptive
- Z30.430: Encounter for insertion of intrauterine contraceptive device
- Z30.431: Encounter for routine checking of intrauterine contraceptive device
- Z30.432: Encounter for removal of intrauterine contraceptive device
- Z30.433: Encounter for removal and reinsertion of intrauterine contraceptive device



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Counseling**

- Z70.0: Counseling related to sexual attitude
- Z70.1: Counseling related to patient's sexual behavior and orientation
- Z70.2: Counseling related to sexual behavior and orientation of third party
- Z70.3: Counseling related to combined concerns regarding sexual attitude, behavior and orientation
- Z70.8: Other sex counseling
- Z70.9: Sex counseling, unspecified



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Counseling**

- Z71.1: Person with feared health complaint in whom no diagnosis is made
 - “Worried Well”
- Z71.3: Dietary counseling and surveillance
 - Code first any underlying medical conditions
 - Use additional code to identify BMI
- Z71.6: Tobacco abuse counseling
- Z71.7: Human immunodeficiency virus [HIV] counseling



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **BMI:**

- Z68 Code series
- Code selection based on age (adult/pediatric), KG, and percentiles based on CDC growth charts
- Codes from this series are required when coding obesity or other dietary/exercise related conditions
- Z68.35: Body mass index (BMI) 35.0-35.9, adult
- Z68.53: Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Problems related to lifestyle:**
 - **Z72.0:** Tobacco use
 - **Z72.3:** Lack of physical exercise
 - **Z72.4:** Inappropriate diet and eating habits
- **High Risk Sexual Behavior:**
 - **Z72.51:** High risk heterosexual behavior
 - **Z72.52:** High risk homosexual behavior
 - **Z72.53:** High risk bisexual behavior



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **HPV Screening**
 - Z11.51: Encounter for screening for HPV
- **HIV Screening**
 - Z11.4: Encounter for screening for human immunodeficiency virus [HIV]



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Pregnancy Test Confirmation**

- Z32.00: Encounter for pregnancy test, result unknown
- Z32.01: Encounter for pregnancy test, result positive
- Z32.02: Encounter for pregnancy test, result negative



Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- **Encounter for Immunization**
 - In ICD-10 the concept of individually specified diagnosis codes (“V” codes in ICD-9) for varying types of immunizations has been abandoned. Only one ICD-10 code exists for immunization encounters:
- **Z23: Encounter for immunization**
 - This code takes the place of over 3 dozen ICD-9 codes for immunization encounters.



SO....

What does this mean to you and your providers?



<http://www.cptcdpros.com/ags/demos.html>



Beware of the 'Unspecified' Coding Monster!!!



- Many carriers will no longer be accepting those 'unspecified' codes that many have grown so accustomed to using; particularly in regards to injury coding and laterality specification.



FP Clinical Examples

21-year-old established client is worried about being promiscuous and would like some counseling on sex practices. She would also like to discuss nutrition and exercise as she is trying to lose weight. Patient is obese due to excess calories with BMI of 34.

The NP spent 25 minutes discussing STD prevention and diet and exercise.

What ICD-10 Code(s) should be billed?



Clinical Examples

ICD-10 code(s) for the encounter:

- Z70.1 – Counseling related to patient's sexual behavior and orientation
- Z71.3 – Encounter for Dietary counseling and surveillance
- E66.01 – Morbid (severe) obesity due to excess calories
Z68.34 – Body Mass Index 34.0-34.9, adult



FP Clinical Examples

Dori has had an IUD for 3 years. She has decided to have a child and would like the IUD removed. She is also a cigarette smoker and would like resources on how to quit to ensure a healthy pregnancy.

The nurse practitioner removes the IUD. She also provides smoking cessation counseling to the patient for tobacco dependence.

What ICD-10 Code(s) should be billed?



Clinical Examples

ICD-10 code(s) for the encounter:

- Z30.432 – Encounter for removal of intrauterine contraceptive device
- Z71.6 – Tobacco abuse counseling
- F17.210 – Nicotine dependence, cigarettes, uncomplicated



FP Clinical Examples

Sara is a 28-year-old female who presents with vaginal symptoms consistent with gonorrhea. She also complains of burning and pain during urination. Diagnostic test for gonorrhea was positive; U/A positive for UTI. Culture and sensitivity showed presence of E. coli. UTI treated with cipro. Rocephin given for gonorrhea.

What ICD-10 Code(s) should be billed?



Clinical Examples

ICD-10 code(s) for the encounter:

- A54.00 - Gonococcal infection, NOS
- N39.0 – Urinary tract infection, site not specified
- B96.20 – Escherichia coli



FP Clinical Examples

Laura presents to discuss family planning and birth control options. Patient was advised of all forms of contraception and has decided to try birth control pills. Patient also complains of fatigue more recently. Patient requested flu vaccination and it was administered. Will order a TSH and prescribe oral contraceptives.

What ICD-10 Code(s) should be billed?



FP Clinical Examples

ICD-10 code(s) for the encounter:

- Z30.011 – Encounter for initial prescription of contraceptive pills
- R53.83 – Fatigue NOS
- Z23 – Encounter for immunization



FP Clinical Examples

19-year-old established client is having menstrual irregularity following placement of the nexplanon implant. She is also experiencing symptoms of mild depression.

Spent 30 minutes discussing the causes of depression and various treatment options. The patient would like to keep the implant but use Lysteda to stop the period.

What ICD-10 Code(s) should be billed?



FP Clinical Examples

ICD-10 code(s) for the encounter:

- N92.6 – Irregular bleeding NOS
- Z30.49 – Encounter for surveillance of other contraceptives
- F32.0 – Major depressive disorder, single episode, mild



FP Clinical Examples

Jen had an IUD inserted 2 weeks ago and now complains of pain at the insertion site with accompanying left lower quadrant abdominal pain.

The nurse practitioner examines the insertion site and has a 15 minute discussion regarding whether to keep or remove the IUD.

The patient decides not to have the IUD removed and will return in a month if symptoms persist.

What ICD-10 Code(s) should be billed?



FP Clinical Examples

ICD-10 code(s) for the encounter:

- Z30.431 – Encounter for routine checking of intrauterine contraceptive device
- R10.32 – Left lower quadrant pain



QUESTIONS?

