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American Academy of Pediatrics
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FAQ for Coding Encounters in ICD-10-CM

Topics:

Encounter for Routine Health Exams

Q. When is it appropriate to report the health exam for child with abnormal findings code (Z00.121)?

A. Refer to the ICD-10-CM guidelines:

Routine and administrative examinations

The Z codes …..

During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Some of the codes for routine health examinations distinguish between "with" and "without" abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for "without abnormal findings." When assigning a code for "with abnormal findings," additional code(s) should be assigned to identify the specific abnormal finding(s).

Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. A secondary code for the abnormal finding should also be coded.

Our *Coding for Pediatrics* manual states that even a minor finding that may not be addressed with a separate E/M service would merit reporting of Z00.121. Likewise a BMI that the physician considers abnormal would support reporting of Z00.121 and the appropriate BMI code.

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Based on this, any abnormality that is present at the time of the routine examination may lead to reporting Z00.121 and a secondary code to describe the finding. This may include, but not limited to an acute injury, an acute illness, an incidental or trivial finding that is diagnosed in the patient's chart, an abnormal screen, an abnormal exam finding (eg, scoliosis), a newly diagnosed chronic condition, or a chronic condition that had to be addressed (excluding medication refill) due to an exacerbation or being uncontrolled or new issues arising related to the chronic condition.

Do not report "with abnormal findings" for a chronic condition that is stable or improving. If the stable or improving chronic condition had to be addressed for medication refill or routine follow-up, you may report the chronic condition in addition to the well child exam "with *normal* findings."

Q. If we report the Z00.121 (health exam with abnormal findings) code, are we required to report a CPT code for a "sick" encounter? Also, by using this code will it negate the use of modifier 25?

A. Please be aware that the new ICD-10-CM code does not impact any CPT guideline. Just because an abnormality is discovered during the routine well child exam does not mean that a separate E/M service should or can be reported. If the criteria are met for reporting a significant and separately identifiable E/M service in addition to the preventive medicine service, then yes one should be reported. However, simply reporting the Z00.121 does not automatically equate to a separate E/M service. As for modifier 25, again CPT guidelines will not be effected, therefore, yes if you are reporting 2 distinct E/M services, then modifier 25 is still required on the "sick" office visit code.

Encounter for Vaccines

Q. Is there only a single code in ICD-10-CM for vaccines as opposed to the more specific codes in ICD-9-CM?

A. That is correct, there is only one single code to report for any vaccine encounter, regardless of what is administered. The code is Z23.

Q. Do we need to report the Z23 code in addition to the health exam codes for children (Z00.121 or Z00.129)?

A. Yes, in the parenthetical under Z23 it states **"Code first** any routine childhood examination**."**

Q. Do I report multiple Z23 codes if there is more than one vaccine given? And do I link to both the CPT code for the product and the administration?

A. You will only report the Z23 once per encounter regardless of the number of vaccines given on a single encounter. Yes, you will link both the CPT code for the product and the administration to the Z23.

Q. We have received denials stating that Z23 cannot be reported as a principal code, what code should we report first when the patient presents for a vaccine encounter only?

A. This is incorrect and they payer is applying inpatient rules to the outpatient setting. "Principal diagnosis" is only relevant for the *inpatient setting* and not the outpatient (eg, physician offices). In the *outpatient setting* we have the "first-listed" diagnosis rule and the Z23 can most certainly be a "first-listed" diagnosis. Please forward all details about a payer's denial for this to the AAP's Coding Hotline aapcodinghotline@aap.org

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Reporting Follow-Up Encounters

Q. How do I report an encounter for a follow-up visit when the condition has been resolved?

A. Per the ICD-10-CM guidelines **"**Do not code conditions that were previously treated and no longer exist." "The follow-up codes (Z08, Z09, Z39) are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code. So for example, patient had recurrent otitis media. You have them return after the antibiotics are completed. Everything is resolved. Therefore your ICD-10-CM codes are Z09 (Encounter for follow-up exam after completed treatment for conditions other than malignant neoplasm) and if you choose to also code the personal history, report Z86.69 (Personal history of other diseases of the nervous system and sense organs) as a secondary code.

Q. What code would I report if the condition is still present?

A. Do not report the follow-up visit code, report the original condition only. Per the ICD-10-CM guidelines "Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code." Therefore report the condition that is present only.

Reporting Injuries

Q. When do we use the 7th character "A" versus the 7th character "D"?

A. There has been much confusion with this issue because of the terminology that was carried over from the WHO version of ICD-10. A stood for initial, while D stood for subsequent. The cooperating parties got together to discuss this to determine as a statistical classification what is the real point of the 7th character for tracking and quality metrics. It was determined that being able to track active treatment versus routine follow up care was what was important. Therefore in 2015 the guidelines were revised to include this.

ICD-10-CM Guidelines:

While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

7th character "A", initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

7th character "D" subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

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Important: The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care.

Q. A patient is seen by his pediatrician after a fall, which resulted in several lacerations. He was initially seen in the ED where sutures were placed. The physician performs and exam and instructs to continue wound care and return in 5 days for suture removal. Would this initial encounter be reported with a 7th character A or D?

A. Based on this information, this is an encounter during the healing or recovery phase therefore despite the fact that this is your initial encounter for this injury, the 7th character is D. The important piece of detail is that the encounter was for care during the healing phase and no active treatment was given.

Q. We submitted a claim for a sequela to an injury. We reported the injury code with 7th character "S" but the claim was denied saying not valid code or not valid as primary. What did we do wrong?

A. Per ICD guidelines: *When using 7th character "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.*

Therefore the injury code with the 7th character "S" must always be secondary.

Suture Removal

Q. Same patient as above returns for suture removal. Do you report the code for suture removal?

A. No because this is an injury that has a 7th character D to define subsequent care. If you will refer to the guidelines above, it states that the aftercare Z codes should not be used in this instance. Therefore you will report the appropriate injury code with 7th character D and not Z48.02 (Encounter for removal of sutures), as Z48 is an aftercare code.

Q. Will the 7th character change for an encounter for suture removal based on whether we were the practice that placed the sutures?

A. No, it will not matter. Even if the initial encounter by your practice is for suture removal, the 7th character will still be "D" because suture removal is considered part of the healing/recovery phase.

External Cause Codes

Q. Are external cause codes required by payers?

A. Per the ICD-10-CM guidelines it states

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily

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report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

When coding for an injury where the external cause is not within the code itself, you can report a code to denote the external cause, place of occurrence, activity and person's status. However, you will only code for the external cause throughout the length of the injury. The place of occurrence, activity and status are only at the initial injury encounter (ie, only reported once per injury). Therefore if the patient was seen in the emergency department for an injury, your office would not code the additional details, only the external cause.

We are not aware of payers who will downcode or not pay if the external cause is not listed, however as in ICD-9-CM some payers will want details on an injury to ensure that another 3rd part payer is not liable. More information could be asked for if nothing but the injury is coded.

External causes are not new to diagnostic coding and if payers required it in ICD-9-CM they will require it in ICD-10-CM. However more payers could require it now with the new system.

Tobacco Exposure

Q. It states specifically at the chapter level in Chapter 10 - Diseases of the respiratory system to "**Use additional code**, where applicable, to identify" any tobacco exposure, whether from a parent or guardian, self or through work. Is this additional code going to be required by payers? If it's not listed will the claim be denied?

A. Since the parenthetical states "*where applicable*" you can only report an additional code if it's applicable. Since it's not applicable for all patients, it will not be required for every claim with a code from Chapter 10 or any place else where tobacco exposure is listed as a "use additional code". However, if you can report the additional code for more detail, you should report it. But it will not be mandatory nor should a payer deny for not including. If you receive a denial for that reason, please inform the AAP's coding hotline AAPCODINGHOTLINE@AAP.ORG .