WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Maximizing Billing and Coding [Part 3]: HIV/AIDS Care Diagnosis Codes

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh. And I'd like to welcome you to the "Maximizing Billing and Coding, Part 3: HIV/AIDS Care Diagnosis Codes" webinar. This webinar is brought you by the Partnerships for Care HIV Training, Technical Assistance and Collaboration Center, or HIV TAC.

The Partnerships for Care project is a three-year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund in the Affordable Care Act. The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV; two, to build sustainable partnership between health centers and their state health department; and three, improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center, or HIV TAC.

Our speaker, again, today is Stacey Murphy. Stacey is a seasoned health care professional with more than 30 years of experience. She's held positions with the Veterans Administration, Lebanon Hospital Center in the Bronx, and other private sector entities. She's an active member of the American Academy of Professional Coders and is very active with the NYMAC chapter in Queens, New York.

She completed her undergraduate work in health administration at St. Joseph's College in Brooklyn, New York, and obtained an executive master's degree from Baruch College in public administration. She received her CPC coding designation in 1998 and is a designated ICD-10 trainer.

Stacey currently teaches health information management and medical coding courses at City University in New York School of Professional Studies. And she teaches medical terminology and other health administration courses at St. Joseph's College. Stacey's latest achievement is as a contributor to the upcoming American Health Information Management Association, AHIMA, white paper "State of Coding in Health Care Today."

Please join me in welcoming Stacey Murphy.

STACEY MURPHY: Well, good afternoon. And thank you for the warm welcome, Steve. So today we're going to be covering ICD-10. Webinar series one and two focused on your CPT and HCPCS codes. So today we're going to do a very, very extensive overview of your ICD-10 codes. We'll do a brief overview of ICD-9. So right now, this is just a disclaimer.

Our learning outcomes are to do a brief overview of ICD-9 codes and its phase-out. We'll identify the various ICD-10 codes that describe AIDS and HIV patient care, identify the ICD-10 coding guidelines for AIDS and HIV patient care, explain the differences between the various codes that are used for AIDS and HIV care. Very important, we'll spend a lot of time talking about diagnosis code selection as well as proper sequencing of the code.

The next two slides are just the acronyms that are used in the webinar series.

So now let's begin with our first polling question for today. What role do you play at your health care facility? Are you clinical staff? The office manager or the supervisor, or front desk/registration personnel? Biller, coder, or insurance follow-up specialist? Or other?

OK, so we have a pretty large group that are more so office managers, supervisors, and front desks. We have billers and coders are 71%. And then we have a small percentage of doctors and office managers. And then we have 18% other.

We have just one more poll. So this is our second one. And we'll move right into the content of the webinar.

Do you possess a familiarity with the ICD-10 coding system? Yes or no. OK, so we have a large number of participants that are actually familiar with ICD-10 codes. So that's great.

So now let's just do a very brief overview of ICD-9. So the ICD-9 coding system has been around since 1948. It was developed by the World Health Organization. And it has been used here in the United States since 1979 for morbidity and mortality statistics. But in 1988, CMS mandated the use of ICD-9 codes on all claims.

So in terms of ICD-10, it's still mandated that we utilize the codes on the claims that we're submitting to the insurance carriers. Just like the codes we're about to review, the ICD-9 codes describe the medical conditions and the diseases, injuries, and poisoning.

The ICD-9 code system was phased out this year on October the 1st and it was replaced with two new coding systems, ICD-10-CM and ICD-10-PCS. In terms of the ICD-9 code system, it's outdated, and it does not describe the emergent technology that's currently used in health care.

In terms of your ICD-10 codes, as we'll see when we go through the slides, there are a significant number of new codes that describe the technology that we are currently using. In terms of the two code systems, ICD-10-CM, those codes are used to report the medical

diagnoses; and ICD-10-PCS, those codes are used to report inpatient hospital institutional clients. So we will not talk about ICD-10-PCS at all. We are only going to focus on the ICD-10-CM codes.

So today is December the 14th, and hopefully you are utilizing the ICD-10 codes at this juncture since ICD-10 was implemented on October the 1st and ICD-9 was phased out on September the 30th. I have been working with a few practices that still have some old claims. And by now, you really should be all caught up and now starting to work on all of your claims for service dates October the 1st to the present. But if you still have some old data out there, make sure that you're using the ICD-9 codes for those. Because if you're submitting old claims for service states through September the 30th, and you're using ICD-10 codes for those claims, those claims will be denied. You should be at this point using the new code set, ICD-10, for all of your claims and all of your services for October the 1st and beyond.

So just some brief information about the two code sets. Your ICD-9 codes are in volumes one and two. There's currently about 13,000 codes versus the ICD-10 code set, which is at 70,000 or more. The ICD-9 codes are three to five characters in length, versus the ICD-10 codes, which are up to seven characters in length.

So using the examples on the slides, the two code sets that we're looking at, they're both the same code length. You have you're 042, which is the codes for AIDS in ICD-9, and you're B20, which is the code for AIDS in ICD-10. In some of the ICD-10 codes, there is use of an x for a dummy placeholder. And we'll see a few of those codes as we start to look at some of the content of the slides.

There are some codes that describe laterality, initial versus subsequent episodes of care, and then there are some combination codes. So we will look at a few of these examples as we start to go through webinar series.

So what has changed? There's new and revised terminology in ICD-10. There's increased use and availability in the number of codes. Again, to repeat, there's codes that reflect laterality, episode of care. The codes reflect increase use of specificity. There's an increase in the use of combination codes.

In ICD-9, there was only 17 chapters in the ICD-9 book. In ICD-10, there are 21 chapters. ICD-10 has plenty of room for expansion in the future. The two code sets that have the most significant changes really don't affect your practice. But they're here for you just so you know-- the musculoskeletal system and the injury and poison section.

In terms of additional changes, if you were using the V codes in ICD-9, those are now your Z codes in ICD-10. If you were using any of the E codes in ICD-9, which described how and where injuries and poisons occur, those codes are now located, or rather they cross map to the V, the W, the X, and the Y codes in ICD-10.

Some additional changes in ICD-10, we just went through the dummy placeholder for code expansion. So really, the only one that would more than likely affect your services would be perhaps the inclusion of the trimester for the obstetrics. It's my understanding that there may be some patients that come to you practice that are pregnant. So you may have to use a seven-digit code. And that seven-digit code will include a dummy placeholder, if applicable.

Now if you are using the seven-digit code, it's very important, if you're using a code book, that you know how to utilize and select the codes based on that seventh-digit designation because there are two different types. One requires that you select the seventh character-- A, D, or S-- and we'll look at that in a minute. A means it's an initial encounter. D means that it's a subsequent encounter. And S is for sequela. We'll look at that in a moment. And the seventh-digit character with the x means that you have to incorporate an x to fill in the space in order to have a code that has seven characters.

Here is the seventh-digit designation for the codes that require the seventh digit for A, D, or S. And then here are just some coding examples or calling guidelines that tell you how that would apply to your code selection. And so again, as we get more involved with the coding guidelines, I'll explain it more in detail.

Another very specific change that affected ICD-10 was the inclusion or the use of excludes 1 and excludes 2. For the coders that are on the call, in ICD-9, you have an excludes and an includes. In ICD-10, you have an excludes 1, an excludes 2, and an includes. The coding guidelines states that for your excludes 1, it follows the same principle as excludes in ICD-9, which means the code that you're selecting cannot be coded at that category. Whereas an excludes 2 means that you can assign an additional code for the medical conditions that you are attempting to report a code for.

So now let's look specifically at some of the chapter content. The next two slides just provide you the overview of the 21 chapters that are in the ICD-10 book with its applicable chapter description. And 7 and 8 are the two chapters that are designated as new sections. In ICD-9, if you recall, the eye and adnexa and the ear and the mastoid process, those were part of the nervous system. Well, in ICD-10, the decision was made to take those out and put those in its own section.

In terms of the codes for AIDS and HIV care, those codes are still in the infectious and parasitic diseases section. So that means that all of the codes that you select for patients who are receiving care for AIDS or any HIV-related diseases, those would be coded from your Chapter 1 codes, A00 through B99.

The next slide just gives you the additional codes that are in ICD-10 book. And so if you remember in ICD-9, the external cause codes and the codes for factors that influence health status, those were designated as your supplementary classification. Well, in ICD-10 the decision was made to put those in and have those as their own unique chapter.

So now let's look at the official coding guidelines for ICD-10. According to the ICD-10 official coding guidelines, the code ICD-10 includes the following terms. So here are some of the various terms that are used to describe care that's rendered to patients that have AIDS. And we'll look at some of the terms for HIV-positive. But in terms of the providers that are on the call, it's very important that you clearly distinguish the documentation for patients that have AIDS versus your patients that are HIV-positive because that is the key driver for the coders who are actually coding from your documentation.

The next slide gives you some additional details from the ICD-10 official coding guidelines. And so if you'll notice the first sentence basically says code only the confirmed cases. It's very important that for patients that come into your practice, if you are utilizing terminology that is stated as probable or a suspicion-- and we'll get to those slides also-- but if you're using that terminology, as a coder, we cannot presume that the patient has AIDS or HIV. It has to be clearly stated in your documentation.

The next slide talks about selection and sequencing of the AIDS and HIV codes. And so I know the slides say patients admitted, but this terminology also applies to patients that come in to the outpatient setting. So that would be your patients that come in and then they are discharged home after they're treated. But in a nutshell, you'll notice with the guidelines, it clearly states that if a patient is admitted for an HIV-related condition, the principal diagnosis should always be B20, an oxymoron here, followed by any additional codes that describe the reported HIV-related condition. If a patient is admitted for an unrelated condition, then that particular condition they are presenting for would be considered the principal diagnosis. And if they have a diagnosis of AIDS or HIV infection, those would be sequenced as your secondary.

So sequencing is very important. It determines the reimbursement for some of those carriers that you participate in that give the quality incentives and other enhanced reimbursement. So it's very important that you, as coders, make sure that you are assigning the appropriate codes based on the documentation. And as the doctors, it's also important that you make sure that your documentation is clear and concise so that the coders can select the correct codes.

The next couple of slides also talk about newly diagnosed asymptomatic HIV. So in terms of a newly diagnosed patient, whether the patient is newly diagnosed or has had it previously, that's not relevant to the sequencing decision. It's determined based on the reason for the patient presenting for medical care.

So again, if they present, and the reason for medical attention is related to AIDS or an HIV infection, that will always be sequenced as the principal. If it's some other medical condition and the patient just happens to have AIDS as one of the diagnoses, the other condition, that occasion, the reason for the patient coming in would be sequenced as the principal.

Official coding guideline d states asymptomatic human immunodeficiency virus infection is to be applied when the patient without any documentation of symptoms is listed as HIV-positive.

So again, it's very important in terms of how this is documented in the record because that's going to be the key driver in how you're going to assign the codes.

The next slide talks about inconclusive HIV- and AIDS-related. So again, if a patient's test results come back inconclusive, then the diagnosis code that you would report for that would be R75, previously diagnosed HIV-related illness. So if a patient has any of those opportunistic infections, this is a patient that is presumed to have AIDS. And so therefore, when a patient has an opportunistic infection or an AIDS-related condition-- they're synonymous with each other-- the principal diagnosis in that case would always be the B20.

So AIDS versus HIV, so according to the Centers for Disease Control, in order to diagnose a patient with AIDS, the documentation must clearly state that they have AIDS or they have an AIDS-defining condition. So again, the ICD-10 coding guidelines are consistent with the CDC's definition of diagnosing a patient with AIDS.

In terms of here in the US, you're only to report confirmed cases of AIDS. The US, typically we only have patients that are HIV-1. But in other countries, they have patients that are diagnosed with HIV-2 or advanced HIV. And so when those persons come to this country, if they have the condition, there is a separate code that describes the HIV-2 condition. So we would just make sure that based on the documentation, you would code it accordingly.

So symptomatic HIV and HIV-positive, they are not the same. So you would never report the two together. So in a minute, we're going to look at some slides. The code B20 would never be reported together with the code Z21. Z21 is HIV-positive, and B20 is a patient or a person diagnosed with AIDS or the HIV infection. HIV-positive and inconclusive, those are never reported together. So again these are just some additional coding tips that you should keep in mind as a coder.

In terms of the patient that are-- or the persons that are coming from other countries, and their documentation states that they have HIV-2, the coding guidelines say that you would report the HIV1 code as the principal diagnosis and the HIV-2 code as the secondary diagnosis.

Inconclusive HIV testing, this is common in newborn babies born to HIV-positive moms, so moms they have the diagnosis, the babies have the diagnosis as a result of the mom's HIV antibody status. So this antibody status typically lasts up to 18 months. And sometimes even after that time span, the newborn does not become diagnosed or HIV infected.

So in the case of these newborns, these are known as false positive. The code book refers to the these as inconclusive HIV tests. So in terms of the documentation, again, it must been very clear so that the coders can assign the most appropriate code.

The next couple of slides is more so for the clinicians on the phone. So the stages of HIV infection. According to the National Institute of Health, there are three stages. And so those three stages are acute, chronic HIV infection, and chronic-- there are two. It breaks out into two

stages of the chronic HIV infection, if you'll notice on the slides. So the first phase is you're asymptomatic for approximately five to 10 years. And then the next phase of the chronic is symptomatic. And that lasts for approximately one to three years. And then you have your advanced stages, where those patients may exhibit some opportunistic infections or AIDS-related conditions

Most people that live with AIDS or HIV face serious health threats and no serious health threats. If those are documented in the medical record, the coders should query the physician just for clarification, especially if the documentation does not state that the patient has HIV, but it mentions those opportunistic infections. So it's very important, again, that there's a correlation between a patient that has AIDS with the common HIV-related opportunistic infections.

People with healthy immune systems can be exposed to the four different types. And sometimes they don't show any reaction. So you have your viral infections, your bacterial infections, your fungal infections, and your parasitic infection. Some of your AIDS-related conditions on the next slide that's coming up, in terms of the clinicians that are on the phone on the webinar, most of this information you already know. So I'm just going to bypass this to get to the information that's more applicable for the coders that are reading your notes or coding from your encounter forms.

So this is just a short list, the most common opportunistic infections. And if you visit the CDC's website, you can get a more comprehensive list. For the purposes of this webinar series, what we tried to do is put together the most common opportunistic infection diagnosis codes for you so that you would have that information handy.

So now we can do polling question number three. And this is a question regarding ICD-10 and submission of your claims. For services to a patient in your office for date of service October the 28th, 2014, you should report ICD-10 codes. Yes or now.

OK. So now we were expecting 100%. So for my participants that have selected True, which is 10%, let's make sure that we're all on the same page. So the date on the polling question denotes October 28, 2014. So we tried to trick you. The ICD-10 codes were implemented on October the 1st, 2015. Although there was a one-year delay, we would have gone live and began using ICD-10 last year, October the 1st, 2014, but CMS made the decision to push the delay back one year. So October the 1st, 2015 is the go-live date for ICD-10. So for this data of service, you should've been using your ICD-9 codes.

So now let's take a moment to look at the codes. What we wanted to do was show you the old codes that you were using, and show you the new codes that you should be using. So these are the two codes that are used to describe AIDS and HIV-positive. Through September the 30th of this year, you were using 042 for your patients that are diagnosed with AIDS. And on October the 1st and beyond, you should be now using B20. For your HIV-positive patients, you were using B08. And now you should be using Z21.

Some other codes that may be familiar to you-- 795.71, for inconclusive HIV; R75 in ICD-10. Your HIV counseling code, V65.44, is now Z71.7. The HIV screening code V73.89 cross maps to two different codes. So if you notice, Z11.4 is the code for HIV screening. And Z11.59 is the code for other viral screening diseases.

V01.79 is your pre-exposure code in ICD-9. And in ICD-10, it's Z20.6 If you'll notice, there is a code for high-risk behavior. In ICD-9, it was B69.2. And in ICD-10, this code maps to three different codes. So if you'll notice, Z72.51 is for high-risk heterosexual behavior. Z72.52 is for high-risk homosexual behavior. And Z72.53 is the code for high-risk bisexual behavior.

Now the reason why the changes were made and the decision was made to further detail the codes is for statistical and reporting purposes.

V69.8 is are there other problems related to lifestyle, Z72.89 in ICD-10. The next codes 079.51 is the code for human T-cell. And in ICD-10, it's B97-34.

Earlier, when we were looking at the slides, we spoke about the HIV-2 infection. The code for HIV-2 is 079.53. And so if you'll notice, there's special coding instructions that say that this code is reported as the secondary code. So this code is never reported alone. And this code is never reported at the principal diagnosis. So if a patient's medical record says that they have the HIV-2 infection, the principal diagnosis is B20 and the secondary diagnosis is B97.35.

The last two codes on this slide are your prophylactic measures. So in ICD-10, it's Z41.8. And you have your screening examination for other venereal diseases, that's the description in ICD-9. In ICD-10, says encounter for screening for infectious with a predominantly sexual mode of transmission. So you'll notice they changed the terminology around. There are quite a few diagnosis codes in ICD-10 that had an overhaul in terminology.

The next two diagnoses are a long-term use of other meds. So you may have a patient that's taking medication for a long period of time. And in ICD-9, the code was the V58.69. And if you'll notice in ICD-10, this is a six-character code, Z79.899. This code is here twice. So I apologize.

So the next slide reflects the codes for your opportunistic infections. So again, what I wanted to do was provide you with the most common codes that describe the opportunistic infections. And because there were just so many codes, and we only have an hour allotted to us, I just provided the code ranges for certain codes.

So if you look, your 112.0 to 112.9 is Candidiasis. And the range for that is B37.0 through B37.9. The CMV code in ICD-9 is 078, but there's a range in ICD-10. So again, the codes on this slide have quite a few codes within that range. So you have to check your code books. Or if you're using an encoder, you could check your encoder to get the most specific code for the opportunistic infection that you're trying to assign.

The second slide is an additional slide. It provides some opportunistic infections. So the mycobacterium avium complex code and I-9 is 031.2 and in I-10, it's A31.2. Your pneumocystis carini pneumonia, 136.3, is B59. So this is just a short list of the diagnosis codes that reflect your common opportunistic infections.

I wanted to also provide the code for your accidental finger sticks. If you work in a setting where your medical office assistants or your LPNs or your nurses are accidentally-- there's an accident because they are drawing blood work on a patient that is known to have the AIDS infection or the virus, and they accidentally puncture themself with the needle, the code in ICD-9 was E920.5. Now this code was never sequenced as the principal. So the same coding guidelines that existed in ICD-9 also exist in ICD-10.

But if you'll notice, in ICD-10, the codes are a seven-digit. The seven-character codes on your ICD-10 side reflect initial encounter, subsequent encounter, and sequela. And the coding guidelines state that when the patient comes in for the encounter for this accidental finger stick, you would first sequence the principal code for screening and testing and counseling. And then this would be the second or third code, depending on what your first and second code that you notated in the chart, that the coders pick up as the principal and second.

The designation of the initial versus subsequent is used not to describe the patient is on an initial visit versus subsequent, like we discussed in E&Ms, but more so to describe the patient's continuing care. So if a patient is coming in for the first encounter, the second encounter, the third encounter, for follow-up care because of the finger stick, the W46.0xxA would be reported for that encounter. And once the physician has determined that the care is completed, then you would report the W46.0xxD. But again, important to remember this code is never sequenced as the principal.

So now you've got two sets of quotes here, one is contact with hypodermic needle, and one is contact with contaminated hypodermic needle. The sequela just means that treatment is completed, but now the patient has another medical condition that they are presenting for treatment. And so since the treatment that they're presenting for is related to the finger stick, then that's when you would use the W46.0xxS or the W46.1xxx, depending on whether it's contaminated or not.

So this slide gives you the overview of what I was just explaining. So the A designates initial encounter. And so as long as the patient is receiving active treatment for that finger stick, the code that you would select will always end in the letter A. Once the treatment is completed and is no longer designated as active, that's when you would select the code with the seventh character D. And sequela just means, like I said, that the patient comes in and now they have new problem as a result of this finger stick.

The next slide talks about patients that are pregnant. The coding guidelines state that if a patient is pregnant and they're coming into your practice for any type of medical attention, the pregnancy code takes precedence over any other code. Now in terms of the codes that you see

here on the slide, there is a dash here at the end of the ICD-10 codes. The ICD-9 code has an x because it's missing a fifth character. But the ICD-10 codes is also missing a character. And the missing characters denote whether or not the patient is in first trimester, second trimester, third trimester.

So again, in terms of your documentation, it's very important that the documentation is very clear and concise because that affords the coders the ability to select the most appropriate code for the encounter that you're providing.

The next slides reflect patients that are coming in for just prenatal care. So let's say, so your V22.0 is supervision of first pregnancy. Your Z34.00 is first pregnancy, unspecified trimester. If you'll notice, the V22.1 is now two codes in ICD-10. So the Z34.80 is for encounter for supervision of other normal pregnancy, unspecified trimester. And this one is encounter for supervision of normal pregnancy, unspecified trimester.

So the codes are first is first pregnancy, and other is everything other than the first pregnancy. So once the mom has the first baby and they come in for prenatal care for a second, third, fourth, and beyond, you would not be reporting that Z34.00. So that one's only used for that first pregnancy.

The Z33.1 is pregnancy state, incidental-- if a pregnant patient comes in for medical attention that's not related to the pregnancy. So let's say, for example, the mom has a headache, but she just happens to be pregnant. The headache is the principal diagnosis because in theory it shouldn't have any effect on the baby, on the unborn child. If the mom comes in for medical attention and it does have an affect, then you shouldn't be reporting these codes. You will go back to one of 098 codes. So in ICD-10, the 098 codes or some other code from the pregnancy section would takes precedence and be sequenced as the principal diagnosis for your pregnant patients. If they're coming in for prenatal care, then you would utilize one of the codes on this slide, a Z34.00, Z34.80, the Z34.90. Or if it's unrelated to the pregnancy and there's no harm to the unborn child, then you would utilize the Z33.1.

So some documentation tips for the pregnancy codes. So in terms of the designation of trimester: first trimester, less than 14 weeks; second trimester, 14 weeks to 28 weeks; third trimester, 28 weeks until the date of delivery. And the seventh character designates the number of fetuses in certain codes that we didn't put on the slide here because again we wanted to just provide you with the information that relates to treatment of pregnant patients that have HIV-related conditions. So that's why if you go back-- let me go back to the slide-- 098.4. I'll go back here. So these slides, these codes pertain exclusively to your patients that are pregnant, but they've been diagnosed with AIDS or are HIV-positive.

Some other codes that are included in the webinar series that may be of interest to you are the well visit codes. Your well visit codes in ICD-9, there are two that you may be commonly familiar with, V70.0. If you're doing any teens or adolescents, more than likely you're using your V20.2 through the ages of 17 or 21, depending on what state you're in. So if you'll notice, the V70.0

code maps to two different codes, Z00.00 and Z00.01. The new coding guidelines state that when a patient comes in for a well visit, if there are any abnormalities found on clinical exam-- and by clinical, rather, I should elaborate, on laboratory or diagnostics-- then you would report your Z00.01 as the principal diagnosis. If a patient comes in and the findings are abnormal, but they are not definitively documented in a diagnostic test, then you have to report the Z00.00.

So again, to repeat, and the only time that you can use your Z00.01 as the principal diagnosis for any abnormal findings is if there is any lab work that is reviewed at the time of the visit or there are any radiology results reviewed at the time of the visit. If there are no diagnostic reports to confirm these abnormalities, then you cannot use the Z00.01 series.

The same applies for the V20.2. There are two codes. You have you with abnormal findings and you have your without abnormal findings. Any of those codes that are denoted as with abnormal findings, you have to report a secondary diagnosis that describes what that abnormal finding code is.

In order to report the code that connotes with abnormal findings, there must be a diagnostic report that denotes what those abnormal findings are. All right. If a patient comes in for that well visit and the physician decides to do any HIV screening or counseling or any of those other services, and there are no abnormal findings as part of that particular encounter, then you would select the code that describes without abnormal findings. So that would be your Z00.00 if it's one of your adult patients, or Z00.129 if it's one of the adolescents.

Here is another slide that has some other codes for use. The V65.49 is another type of a counseling code. And it maps to three different codes in ICD-10. So your Z70.0 is counseling related to sexual attitude. Z70.1 is counseling related to patient's sexual behavior and orientation. And the Z70.3 is counseling related to sexual behavior and orientation of third party, such as a child, a partner, or a spouse.

So again, there's more specific codes that are available in ICD-10 as opposed to what we formerly had in ICD-9. Just some coding tips for the coders that are on the line, never report the code for AIDS and HIV-positive when the documentation states suspicion of, suspected, possible, likely, rule out, questionable, consistent with, presumed to be, or appears. So instead, whatever the doctor documents in the record as the presenting complaint, that's what you would assign as the final call. But as an alternative, if you work in a practice setting where you have access to query the physician, then you could query the physician and allow that position an opportunity to go in and do an amendment to the record.

Some additional tips active versus history of. So if the doctor documents active, the code for active translates to B20. And if it's an HIV-positive patient, then it translates to Z21. Since there are no codes for history of, the patient-- really and truly, I would say query the physician. But if you work in a practice setting where you are familiar with the patients that are coming into your practice, then you know what their diagnosis is from your prior visits. But the doctor really

should take the time to clearly document in the medical records so that there's no ambiguity in the event of an audit, an outside auditor comes in to do an audit of your records.

So now let's look at polling question number for. The codes for AIDS in ICD-10 should always be reported as the principal diagnosis on all of your patient encounters. Is that true or is that false?

OK. So once again I was looking for a 100% false on this one. According to the ICD-10 coding guidelines, the selection of the principal diagnosis is based upon the treatment that the patient is coming in for. So if the medical record states that the patient is presenting because they have an AIDS or HIV-related condition, and that's the reason for medical attention, then that's going to be your principal diagnosis. If the patient is coming in for a headache or they have a fracture of the ankle, and they just so happen to also have a diagnosis of AIDS or HIV infection, then the fractured ankle would be the principal diagnosis and the AIDS or HIV infection would be the secondary diagnosis. All right?

So now let's look at a few coding scenarios because we're winding down. So we have quite a few coding scenarios, so we won't go through all of those. The first one is a patient that comes into their primary care physician's office complaining of recently having or rather concerned about having unprotected sex. And they request an HIV test.

The physician notices that the patient hasn't had any of the well visits in the past year. So they decide to also do the well visit. So if you'll notice, what we tried to do for you is provide the ICD-9 codes that you would have reported. And we also provided the ICD-10 codes that you should be reporting as of October the 1st. So this, B70.0 is what you would have reported in I-9. There is your Z00.00, your screening code Z11.4, your counseling code Z71.7, and high risk sexual behavior, Z72.51.

And so the next slide just gives you the rationale. This as a general medical exam, well visit. The patient has no real complaints, but they're coming in concerned that because they've had unprotected sex, they wanted to have a test, an HIV test. So the principal diagnosis again is Z00.00. Your secondary is Z11.4. Your HIV counseling, Z71.7. And then you have your Z72.51.

The next scenario is a kind of a continuation from the previous. So the patient returns for their results. And the physician advises the patient that the results are negative. So they've not been diagnosed with the HIV infection or AIDS. The physician counsels the patient for 30 minutes on the importance of safe sex, gives some contraceptives, and advises the patient to come back in for a retake in three months.

So again, you're reporting V65.44 in I-9. You should be reporting Z71.7. The high risk behavior code is still here, Z72.51. And then the next slide gives you the rationale.

I'm going to skip ahead. This is the same patient. They come in for their results. The physician tells the patient that they're HIV-positive. So the principal diagnosis is Z21. The secondary diagnosis is for counseling, Z71.7.

And then here's the rationale on the next slide. Here's your rationale. So the physician counsels the patient, gives them some literature, explaining what HIV is and the difference between AIDS and HIV. Also discusses the importance of safe sex. Your principal diagnosis, Z21. Your secondary diagnosis, Z71.7.

The next scenario, same patient. They come in for their results. The physician advises the patient that they have the HIV infection. The principal diagnosis changed. Instead of Z21, it's now B20.0. The counseling code is still the same, Z71.7.

And so your rationale's on the next side. All right. The next slide is for a patient who comes in. They're not a regular patient of yours. They come into your practice. They've come in for their results after they've taken the test. And the principal diagnosis is B20 because this is a patient that has advanced HIV-2. So the principal diagnosis is B20. The secondary diagnosis is B97.35 and Z71.7.

I'm going to turn it back over to Steve because we only have about a minute left. But the PowerPoint webinar series has lots and lots of examples for you. And if you have any questions, feel free to send those along to Steve, and I will certainly put together a Q&A packet and answer all your questions.

This slide just speaks about doctors and reimbursement and the key driver is now changed. If you're still using paper charts, make sure that you're using abbreviations that are common in health care. A few slides that were ahead of this one are all of the resources that were used in the webinar series. So if you could just quickly take a couple minutes to read this case study.

OK, so it looks like we have a nice number of people that have selected false. And we do have a small percentage of individuals that have selected true. The answer is false.

The patient presented for their test results. And they just so happened that they also are hypertensive and they needed their prescription refilled. So again, the principal diagnosis is the key driver based upon why the patient presented and what medical attention the provider is going to give to that patient. So if it's related to the patient's condition, then that will be the principal diagnosis.

So they're coming in for their results, and they also need a prescription. But because they were coming in for their results, and the results are positive, that's the principal diagnosis as opposed to the hypertension. All right?

So just some closing comments because it's already 4:03. Medical record documentation must support the services that are provided if you're going to be submitting any claims to your local Medicaid agency and any of the insurance carriers because on occasion they do come in and do a chart audit. And if they come out and due a chart audit and the information that's documented does not coincide with what's in the record, they do take the money back. So documentation must substantiate the reason for treatment and the final diagnosis.

Any inaccuracies result in payment recovery. Sometimes it fines, termination of provider participation in the health plans, restricted or excluded provider participation, and sometimes there's even jail time. For my coders that on the phone, some of the web resources that you can utilize are the coding resources from the professional coding societies, AAPC and AHIMA. There are also some other resources that you can use, ICD-10 books-- because, remember, we're no longer using ICD-9. You can use your ICD-10 book. There's a [INAUDIBLE] coding handbook that provides some detailed information for coders. And then they have these little cheat cards called ICD-10 fast-finders for providers.

So now I'm going to turn it back over to Steve.

STEVE LUCKABAUGH: OK. We have one more polling question. We know that some folks listen alone. And some log in and listen with big groups. And we're very interested in knowing just how many actual people are listening.

So we have this last poll here. How many people are you viewing this webinar with? So are you by yourself, or do you have two or three or whatever? If you enter five or more, then please enter the actual number in the questions pane in the GoToWebinar toolbar. So if you're in a group of, let's say, 10, just put the number 10 in the questions pane in the GoToWebinar toolbar. So we know exactly how many.

So while we're waiting for you respond to that, we can take some questions now. So if you'd like to enter your questions in the questions pane, we can go through some of those. OK, and I will close the poll now.

So it looks like most are either individual or groups of two. So that's good to know. Thank you for everyone that contributed to that.

So if you have any questions, please enter them now. OK, we have one. How should we document it if insurance companies will only provide housing/other assistant type services if they are symptomatic?

STACEY MURPHY: How should they document the care that they're providing to the patient?

STEVE LUCKABAUGH: I'm not really sure.

STACEY MURPHY: Maybe let's let the caller--

STEVE LUCKABAUGH: OK. If you could clarify on that. We can move on to the next one. Should the Z41.8 be used for PrEP if we prescribe PrEP for the patient?

STACEY MURPHY: Z or V?

STEVE LUCKABAUGH: Z as in zebra.

STACEY MURPHY: Z as in zebra. OK. For PrEP, it should be Z-- I don't remember a V41. I think we have the Z71.7 for counselling, Z11.4-- the PrEP slide, if you-- can we go back? There was a code for PrEP. And I'm just trying to-- Z20.6, if I'm not mistaken, is the code for the PrEP, the Pre-Exposure Prophylaxis, Z20.6.

STEVE LUCKABAUGH: OK. I'm still waiting on clarification for the other question. All right. Now I don't have any other questions. If anyone else has any questions, please enter them now.

STACEY MURPHY: Oh, I see which code they're referring to. That's for other specified-- To answer that caller, they want to use the code that is as specific as possible for the care that's being provided. And according to the code that most payers are looking for in terms of when you submit your claims, that would be your Z20.6.

What was that code that they asked about? The other code is for other types of prophylactic measures. So remember in ICD-10-- well, actually, in ICD-9, there were only about 13,000 codes. And in ICD-10, there are 70,000-plus codes.

So everything is more specific. The level of detail in terms of your code description should help you to select the most specific code based on what's documented in the patient's record.

STEVE LUCKABAUGH: OK. And one person asked if you'll be able to download and save the slides. And yes, you can. If you go to the Handouts section on the GoToWebinar toolbar, you'll see the slides for today as well as the slides for parts one and two of this series. So you should be able to grab all three of those right now if you want to.

We have another question. For the PrEP, would you also include the high risk code as well?

STACEY MURPHY: Again, that would be clearly based on the documentation. So if high risk was documented in the medical record, then yes, you would assign the code for high risk. If it wasn't documented, then you have two choices. You can go back to the physician and get clarification. Or you would just code the Z20.6.

STEVE LUCKABAUGH: OK. Does anyone else have any questions before we wrap it up? OK. Another question is would contact or exposure with a hypodermic needle also include heroin users?

STACEY MURPHY: Anytime you're-- well, this code is for anyone who is exposed to-- I guess, is punctured by a needle as a result of any kind of interaction. So it's not just for in the office setting. It could be two individuals sharing needles, and one is accidentally punctured with the needle. But for the example that I provided, I wanted to just bring an element of what happens in the office setting because we had some of those kind of examples in one of the previous webinars where an employee was injured as a result.

STEVE LUCKABAUGH: OK. Any other questions? OK, we have another question. Is it true that mid levels cannot see workers compensation patients?

STACEY MURPHY: It depends on what the rules are in your specific state. Because in the state where I am, we have NPs that are able to see the workers comp. I'm in the New Jersey, New York side. So you would have to check to see what the specific credentialing criteria is for that health plan and/or for your state Medicaid agency.

STEVE LUCKABAUGH: OK, so in this case, it's New York.

STACEY MURPHY: Mhm. Well, yeah, because I'm in the New York, New Jersey side. Oh, so your practice is also in New York?

STEVE LUCKABAUGH: Yes.

STACEY MURPHY: OK. So yeah, we have practices that have NPs and PAs that are actually seeing patients that have workers comp insurance, and they're reimbursed. So you have to make sure that you're properly credentialed and whether or not that particular workers comp carrier credentials mid-level providers.

STEVE LUCKABAUGH: OK. Any other questions? OK, we've got a couple "thank you very much's." So that's always good.

STACEY MURPHY: Oh. Appreciate it. Thank you for joining.

STEVE LUCKABAUGH: All right. Any closing thoughts before we wrap it up here?

STACEY MURPHY: I hope that this ICD-10 presentation was helpful. And on Friday, we will pull everything together using the ICD-10, CPT, HCPCS. And we will show you scenarios that will hopefully help you to ensure that your coding properly when you're submitting your claims.

STEVE LUCKABAUGH: OK. Thank you for participating in today's webinar. And we hope you find the information provided useful as you continue your P for C project. And we ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You'll also receive it via email.

Today's webinar contained a lot of very detailed information. And I know you're going to want to review it again. You're in luck. Today's was recorded, and audio and video versions of the entire webinar, as well as the slides from today's webinar, will be made available on the P for C website in the next few weeks.

Copies of all our prior P for C webinars are currently available on the website on the P for C Resource Materials page at p4chivtac.com. You will need to log in to access the materials. If you need log-in credentials, send an email to p4chivtac@mayatech.com.

Also a reminder that part four of this series will be on Friday this week, December 18, at the same time, 3:00 PM Eastern time. So be sure to register for that. Registration information will be sent out via the listserv. So be on the lookout for that.

Thank you again for participating in today's webinar. And thank you once again, Stacey, for that excellent presentation. If you have any additional questions for the P for C project, or for Stacey, please email us at pforchivtac@mayatech.com. Take care everybody. And we'll see you next time.