Podcast Transcript

Title: Coding with Ann: Best Practices for ICD-10 Diagnosis Coding for STD and HIV Screening
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NCTCFP: Welcome to today's podcast sponsored by the National Clinical Training Center for Family Planning, and part of an ongoing series called "Coding with Ann". The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest speaker is Ann Finn from Ann Finn Consulting LLC. Ann is a healthcare reimbursement consultant and a national trainer with many reproductive health care organizations. Welcome, Ann!

Ann Finn: Thank you. Welcome to my new listeners and welcome back if you have listened to other podcasts in our "Coding with Ann" series. We're very excited by the great response from our listeners to date and that we are able to offer these short, focused coding sessions to provide you with some tips and guidance to ensure that you are able to efficiently capture and code for your services in order to be paid appropriately.

Today's podcast will focus on some common ICD-10 diagnosis codes and guidance for STD and HIV screening visits.

Let's start with reviewing what the ICD-10-CM Official Guidelines for Coding and Reporting for Fiscal Year 2018 define screening as:[1]

- Screening is 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 or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.
- A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems.

[1] *ICD-10-CM Official Guidelines for Coding and Reporting for FY 2018*
https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

- A screening code is not necessary if the screening is inherent to a routine examination, such as a Pap smear done during a routine pelvic examination. Should a condition be discovered during the screening, then the code for the condition may be assigned as an additional diagnosis.
- The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed. When screening for STDs, we would typically use codes found under the family - Z11 Encounter for screening for infectious and parasitic diseases such as Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission or STD screening. There are other specific codes that may be selected depending on what service is provided such as: Z11.51 Screening for HPV or Z11.59 Screening for hepatitis B, as examples. It's important to review and understand the new codes available under ICD-10.

Let's touch on some tips from the ICD guidelines for coding encounters for screening for HIV:

1. If a patient is being seen to determine his or her HIV status, we would use the code Z11.4 Encounter for screening for HIV. We may also include additional codes for associated known risk factors. A few examples include: Z72.52 High-risk homosexual behavior, or Z72.53 High-risk bi-sexual behavior, W46.1- Contact with contaminated hypodermic needle or Z77.21 Contact with and (suspected) exposure to potentially hazardous body fluids.
2. If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms as diagnostic testing rather than screening.
3. Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of HIV. It is important that you code the HIV disease specific codes such as B20 or Z21 only when you are dealing with confirmed cases of HIV infection or illness.
4. In each of these cases, an additional counseling code- Z71.7, HIV counseling, may be used if related counseling is provided during the encounter for the test.
5. When a patient returns to be informed of his/her HIV test results and the test result is negative, you can use the code Z71.7 to capture the HIV counseling provided.
6. If the results are positive, then we can refer to the ICD official guidelines and assign codes as appropriate. Again, only code HIV infection or illness codes with confirmation.

People often ask me when should they use history codes such as Family history of or Personal history of codes.

- According to the ICD-10 guidelines, there are two types of history Z codes: personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.
- Family history codes are used when a patient has a family member or members who have or had a particular disease that causes the patient to be at higher risk of also contracting the disease. An example is Z83.0 Family history of HIV disease.
- Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are acceptable on any medical record regardless of the

reason for the visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.
- An example of a code we might use for patient that has a personal history of a sexually transmitted disease would be Z86.19.

What if the patient presents because they came in contact with someone with an STD?
- Category Z20- indicates contact with, or suspected exposure to, communicable diseases. These codes are for patients who do not show any sign or symptom of a disease, but are suspected to have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. Examples of this include Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission for STD Screening or Z20.6 Contact with and (suspected) exposure to HIV.
- Contact and exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

What are Status Codes and how are they different from a history code?
- Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition. An example would be Z21 Asymptomatic HIV infection status. This code indicates that a patient has tested positive for HIV, but has manifested no signs or symptoms of the disease.

So let's look at a common scenario together.

- Steve, our 22-year-old patient who is new to the clinic, has learned his partner has had other partners and is now being treated for gonorrhea. He is asymptomatic, but requests to be screened for a STI. Urine samples are taken for the necessary tests including gonorrhea and chlamydia. He is also given a HIV Rapid test, which is negative. The clinician counsels Steve on sexually transmitted infections and ways to reduce transmission and exposure for 8 of the 13 minutes of the clinician's face-to-face encounter. Steve is going to return later in the week for his test results. What ICD-10 diagnostic codes would we need for this visit?
    - Since Steve was being tested based on potential exposure to a disease from his partner, we may use the code Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission for the counseling and assessment and for the gonorrhea and chlamydia tests that were ordered. We would also include the code Z11.4 HIV testing to support the medical necessity of the HIV rapid test in-house test that was performed.
    - What if the clinician presumptively treats Steve for gonorrhea and assigns a code for gonorrhea disease rather than the appropriate screening or signs and symptom codes during this visit? A few days later, the test results come back negative. Steve's record now reflects a disease that he does not actually have. We would now need to amend the medical record to correct this error. Remember, you should only assign disease codes with confirmation.

Here are a few suggestions or tips to help you develop stronger coding skills:

1. First, each healthcare encounter should be coded to the level of certainty known for that encounter. If the patient is asymptomatic then use the screening and contact with ICD codes; otherwise, code for the signs and symptoms they present with. Don't assign diseases to a patient without confirmation.
2. Review the official ICD-10 coding guidelines to ensure that you understand the coding rules for different services including screening, signs and symptoms and the actual disease family. These can be downloaded from cdc.gov website.
3. Attend a coding training to help you feel more comfortable with ICD-10 coding. The transition to the new code set was significant and it takes time to fully learn and understand the new codes available for you to use now.
4. Documentation matters. Remember the old saying, if it's not documented, it can't be coded and billed for.
5. Follow-up on any claims that are not paid in full and resolve the root cause of the payment issue so that it is not repeated.
6. Have a small sample of your charts reviewed by other clinical staff or by an outside reviewer and ask for their constructive feedback.
7. And, finally, mentor other staff and share your findings so that your practice develops compliant coding practices and is reimbursed appropriately for all your services.

Thanks for joining us today. I hope these tips were helpful and can be easily implemented into your coding practices. Be sure to check out the other podcasts available in our Coding with Ann series.

NCTCFP: Thank you, Ann, for this information. To listen to the other podcasts in this series or for more resources on billing and coding in family planning settings, please visit our website www.ctcfp.org, or call us at 1(866) 91-CTCFP - that's 1 (866) 912-8237. A transcript of today's podcast is available for download on our website. Thank you.