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Coding *and* Payment Guide *for* Behavioral Health Services

An essential coding, billing, and payment resource for the Behavioral Health Provider

Introduction

Coding systems and claim forms are the realities of modern health care. Of the multiple systems and forms available, what you use is greatly determined by the setting, the type of insurance, and your practice style.

This book provides a comprehensive look at the coding and reimbursement systems used by behavioral health providers. It is organized topically and numerically, and can be used as a comprehensive coding and reimbursement resource and as a quick-lookup resource for coding.

Coding Systems

The coding systems discussed in this coding and payment guide seek to answer two questions: What was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, statisticians could identify effective treatments as well as broad practice patterns. Before long, these early coding systems emerged as the basis to pay claims.

Under the aegis of the federal government, a three-tiered coding system has emerged for physician offices and outpatient facilities. *Physicians' Current Procedural Terminology* (CPT®) codes report procedures and physician services. A second level, known informally as HCPCS, comprises the second level and the codes largely report supplies, non-physician services, and pharmaceuticals. A third level of codes is used on a local or regional basis and is of diminishing importance. Dovetailing with each of the levels is the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) classification system that reports the diagnosis of illnesses, diseases, and injuries. (A portion of ICD-9-CM, Volume 3, also contains codes for inpatient procedures and is used exclusively by inpatient facilities.)

ICD-9-CM Codes

ICD-9-CM is used to classify illnesses, injuries, and patient encounters with health care practitioners for services.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is a classification tool developed by the American Psychiatric Association as a reference to provide guidelines in diagnosing and classifying mental disorders. The DSM-IV is used primarily as a clinical guide for diagnosing the patient. Code sets in the DSM-IV relate closely to ICD-9-CM Volumes 1 and 2 diagnosis codes. Coders are advised to use the DSM-IV as a reference to arrive at a diagnosis, but use the ICD-9-CM for the actual coding.

The ICD-9-CM classification system is a method of translating medical terminology into codes. Codes within the system are either numeric or alphanumeric and are composed of three, four, or five characters. A decimal point follows all three-character codes when fourth and fifth characters are needed. "Coding" involves using a numeric or alphanumeric code to describe a disease or injury. For example, depression with anxiety is classified to 300.4.

Generally, the reason the patient seeks treatment should be sequenced first when multiple diagnoses are listed. Claim forms require that the appropriate ICD-9-CM code be reported rather than a description of the functional deficits.

Health care providers need to be aware of the necessity for specific diagnosis coding. Using only the first three digits of the ICD-9-CM diagnosis code when fourth and fifth digits are available results in invalid coding.

HCPCS Level I (CPT) Codes

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups, have developed, adopted, and implemented a three-level coding system describing services rendered to patients. Level I is the CPT coding system.

The most commonly used coding system to report outpatient services is CPT, which is published annually and copyrighted by the AMA. CPT codes predominantly describe medical services and procedures, and have been adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are widely used and required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs.

The AMA's CPT Editorial Panel reviews the coding system annually and adds, revises, and deletes codes and descriptions. New codes go into effect January 1 of each year. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the services.

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (Health Care Common Procedure Coding System — pronounced "hik piks"). HCPCS codes are used to bill Medicare and Medicaid patients and have also been adopted by some third-party payers.

HCPCS Level II codes, updated and published annually by CMS, are intended to supplement the CPT coding system by including codes for non-physician services, durable medical equipment (DME), and office supplies. These Level II codes consist of one alphabetic character (A through V) followed by four numbers.

Non-Medicare acceptance of HCPCS Level II codes is idiosyncratic. Providers should check with the payer before billing these codes.

HCPCS Level III (Local) Codes

All HCPCS local codes have been phased out, a process that began in 2002. As the first step, effective October 16, 2002, carriers were required to eliminate all local codes and modifiers that had not been approved by CMS. Carriers had to identify those codes and modifiers in use, crosswalk them to national codes, and delete any that were not approved. If carriers felt that an unapproved code should be retained for use, they had to submit a request for a temporary national code for that service/supply, with an explanation as to why the code should be retained. These requests were due to the regional offices by April 1, 2002.

The next phase was the elimination of the official HCPCS Level III local codes and modifiers by December 31, 2003. Again, carriers were required to review all local codes in their systems, crosswalk them to appropriate national codes, and submit requests for replacement temporary national codes by April 1, 2003. Temporary national codes that are requested and approved will be implemented January 1, 2004.

Local codes had been used to denote new procedures or specific supplies for which there was no national code. For Medicare, these five-digit alphanumeric codes used the letters W through Z. Each carrier created local codes as the need dictated. However, carriers were required to obtain approval from CMS's central office before implementing them. The Medicare carrier was responsible for providing you with these codes.

As a result of the Consolidated Appropriations Act of 2001, and as part of the National Code Data Sets implemented under the Health Insurance Portability Accountability Act, the Secretary of Health and Human Services was instructed to maintain and continue the use of HCPCS level III codes through December 31, 2003.

Program Memorandum (PM) AB-01-45 instructed carriers to take the following steps to implement the law on April 29, 2001:

- Maintain and accept current level III HCPCS codes and modifiers until December 31, 2003. However, carriers were not allowed to create any new HCPCS Level III codes or modifiers.
- Carriers were to reinstate any HCPCS Level III codes and modifiers they may have eliminated after August 16, 2000.
- Carriers were to publish on their Web sites any HCPCS Level III codes and modifiers with their descriptors that were in effect August 16, 2000.

Medicare carriers who wished to establish a temporary national code were required to submit the request to their regional office. The regional office then submitted that recommendation to the central office for approval.

Claims Forms

Institutional (facility) providers use the UB-92 claim form, also known as the CMS-1450, to file a Medicare Part A claim to Medicare Fiscal Intermediaries. Non-institutional providers and suppliers (private practice or other health care provider's offices) use the CMS-1500 form to submit to Medicare Carriers for Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities, hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, skilled nursing facilities, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-92, depending on the payer.

For professional component billing, most claims are filed using ICD-9-CM diagnosis codes, CPT procedure codes, and CMS-1500 forms.

While discussing claim forms, it is important to note that due to the administrative simplification provisions of HIPAA regulations due to be implemented in 2003, health care plans, clearinghouses, and providers who transmit health care information in electronic form will be subject to the electronic data interchange (EDI) standards for certain types of information exchanges. All health care providers using electronic transmittals will be able and required to use a uniform set of EDI standards for their billing and other health care transactions, and all health plans will be required to accept these standard electronic claims. The vast majority of inpatient claims are already submitted in this format, as well as the largest percent of provider claims. Providers submitting information by paper will not be affected by these rules, but privacy compliance must always be maintained.

The advantages of electronic claim submission over paper claim submission are many. Clean electronic claims are paid in about half the time of clean paper claims, costs are greatly reduced, and your staff spends less clerical time in claim processing. Errors can be minimized due to built-in edits that prevent common errors and omission of required data field information. You receive transmission and validation reports electronically that notify you of successful file transfers, as well as an "Error/Acceptance" report within 24 hours that tells you how many claims were accepted and how many were rejected due to invalid or missing information.

Check with your local Medicare carrier about billing software available for those interested in filing claims electronically.

A step-by-step guide for completing the CMS-1500 and UB-92 claim forms and an explanation of the claims filing process can be found in the Claims Processing section.

Contents and Format of This Guide

Coding and Payment Guide for Behavioral Health Services contains chapters that address reimbursement, definitions

The Reimbursement Process

Receiving appropriate reimbursement for health care services can sometimes be difficult because of the myriad of rules and paperwork involved. The following recommendations will help you understand the various requirements for getting claims paid promptly and correctly.

Coverage Issues

First, you need to know what services are covered. Covered services are services payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be documented and medically necessary for payment to be made. Typically, payers define medically necessary services or supplies as:

- Services that have been established as safe and effective
- Services that are consistent with the symptoms or diagnosis
- Services that are necessary and consistent with generally accepted medical standards
- Services that are furnished at the most appropriate, safe, and effective level

Documentation must be provided to support the medical necessity of a service, procedure, and/or other item. This documentation should show:

- What service or procedure was rendered
- To what extent the service or procedure was rendered
- Why the service, procedure, or other item(s) was medically warranted

Services, procedures, and/or other items that may not be considered medically necessary are:

- Services that are not typically accepted as safe and effective in the setting where they are provided
- Services that are not generally accepted as safe and effective for the condition being treated
- Services that are not proven to be safe and effective based on peer review or scientific literature
- Experimental or investigational services
- Services that are furnished at a duration, intensity, or frequency that is not medically appropriate
- Services that are not furnished in accordance with accepted standards of medical practice
- Services that are not furnished in a setting appropriate to the patient's medical needs and condition

Payer Types

Most providers have to deal with a number of different payers and plans, each with its own specific policies and methods of reimbursement. For that reason, it is important to become familiar with the guidelines for every payer and plan that your practice has contact with. Some insurance plans are administered by either the federal or state government, including Medicare, Medicaid, and TRICARE. Private payers range from fee-for-services plans to health maintenance organizations.

Medicare

Administered by the federal government, Medicare provides health insurance benefits to those 65 years of age and older, and individuals of any age who are entitled to disability benefits under Social Security or Railroad Retirement programs. In addition, individuals with end-stage renal disease that require hemodialysis or kidney transplants are also eligible for Medicare benefits. Consisting of two parts, Medicare Part A (for which all persons over 65 are qualified) covers hospitalization and related care while Part B (which is optional) covers physician and other related health services. Fees for Medicare services are based on the Medicare fee schedule.

In addition, the Medicare+Choice plan, created in 1997 as part of the Balanced Budget Act (BBA), allows managed care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), to join the Medicare system. Access to these various options depend on where the beneficiary lives and the availability of plans in their community.

Medicaid

Medicaid is administered by the state governments under federal guidelines to provide health insurance for low-income or otherwise needy individuals. In addition to the broad guidelines established by the federal government, each state has the responsibility to administer its own program including:

- Establishing eligibility standards
- Determining the type, amount, duration, and scope of services
- Setting payment rates for services
- Program administration

TRICARE

Formerly called CHAMPUS, TRICARE provides health insurance to active and retired military personnel and dependents.

Blue Cross and Blue Shield

Blue Cross (hospital services) and Blue Shield (physician services) were the first pre-paid health plan in the country. Although all "Blues" plans are independent, they are united by membership in the national Blue Cross and Blue Shield Association (BCBSA). The Blue Cross and Blue Shield System is responsible for the administration of the four million-member Federal Employee Program (FEP), comprising all federal government employees, retirees, and dependents.

Health Maintenance Organizations (HMOs)

The most common form of managed care is the HMO. This type of plan has several variations, but basically, the subscriber pays a monthly fee for services, regardless of the type or amount of services provided. The primary care physician (PCP) acts as a gatekeeper to coordinate the individual's care and to make decisions regarding specialty referral and care. In a "group model" HMO, referrals for care outside of the large independent physician group must be arranged, care for emergency services must be preauthorized, and information about care provided in a life-threatening situation must be communicated to the plan within a specified period of time. On the other hand, the managed choice model HMO allows individuals to access care via the PCP or to go outside of the network to receive care without permission of the PCP, but at a lower level of benefits.

Preferred Provider Organizations

Preferred provider organizations (PPOs), are generally contracted by an employer group or other plans to provide hospital and physician services at reduced rates. Although coverage is higher for preferred or participating providers, individuals have the option to seek services provided by non-participating providers. A variation of the PPO is the exclusive provider organization (EPO,) where enrollees must receive care within the network and must assume responsibility for all out-of-network costs.

Point-of-Service Plans (POS)

Point-of-service plans permit covered individuals to receive services from participating or nonparticipating providers, but with a higher level of benefits when participating providers are used.

Independent Practice Association (IPA)

This type of organization comprises physicians that maintain separate practices and participate in the IPA as a means to contract with HMOs or other health plans. The physicians also generally treat patients who are not members of the HMO or other plans.

Indemnity Plans

Under indemnity plans, the payer provides payment directly to the provider of service when benefits have been assigned by the patient. Many carriers now include PPO attributes to help reduce costs.

Third-Party Administrators (TPAs) and Administrative Services Organizations (ASOs)

Although neither insurers or health plans, TPAs and ASOs manage and pay claims for clients such as self-insured groups. The self-insured group then assumes the risk of providing the services and may contract directly with providers or use the services of a PPO.

Physician Hospital Organization (PHO)

Hospitals and physician organizations may create a PHO to assist in managed care contracting on behalf of the parties. Degrees of management, common ownership, and oversight vary depending on the model of the arrangement.

Payment Methodologies

Once covered services are known, the next issue to resolve is how you will be paid for those services. Over the last several years, there have been major changes to provider payment systems. The following will discuss the many varieties of payment methodologies used by Medicare and other third-party payers for outpatient and inpatient claims.

Diagnosis-related Groups (DRGs)

DRGs apply to inpatient acute hospital/facility settings only, grouping multiple diagnoses together. Reimbursement is based on this grouping rather than on the actual services. Inpatient stays typically use revenue codes to describe the treatments or procedures rendered.

Ambulatory Payment Classifications (APCs)

APCs, Medicare's new outpatient prospective payment system, is a methodology for payments to hospitals for a wide range of facility services when performed on an outpatient or a partial hospitalization basis. It differs from DRGs in that DRGs are drived by ICD-9-CM diagnostic groups, where APCs are grouped by the actual service provided. CPT and HCPCS codes are grouped into payment groups, with a fixed payment for each group that is geographically adjusted. Some services are exempt from APCs and will still be paid by fee schedule.

Some services have been exempted from APC payment methodology and will continue to be paid in accordance with the respective fee schedules for these specific services. These services include end-stage renal disease services, laboratory, durable medical equipment, screening mammography, ambulance services, pulmonary rehabilitation, and clinical trials.

For more information on APCs, see our Ingenix Publications identified in the front of this publication.

Usual, Customary, and Reasonable

Fee-for-service reimbursement based on reasonable and customary charges has been the typical payment method to reimburse providers over most of Medicare's history (as well as private payers). Medicare's previous "customary, prevailing, and reasonable" (CPR) payment methodology was similar to the private sector's charge system of "usual, customary, and reasonable" (UCR).

This payment system is designed to pay providers based on their actual fees. The provider is paid the lowest charge among the actual fee for the service, the provider's customary charge (the median of that individual's charges for the service over a defined time), or the prevailing usual charge of all providers within the area. There was no attempt to reimburse services based on the work required. Owing to the diversity in fees charged for the same services, this system allowed for a wide variance in payment for the same service. As health care costs exploded in the 1970s

Documentation — An Overview

The role played by medical documentation has always been a supportive one. As the practice of medicine became sophisticated and complex, the need to record specific clinical data grew in importance. What certainly began as a simple written mechanism to jog the memory of a treating physician evolved into a more refined system to service others assisting in patient care. Tracking patient history emerged as a fundamental element in planning a course of treatment. When medical specialties evolved early in the last century, the patient record offered a means to provide pertinent data for referrals and consultations.

Still, until about 35 years ago, no clear standards existed for recording patient information. Medical documentation was seen, maintained, and used almost exclusively by physicians and medical staff. Patient care information was never submitted to insurance companies or to government payers; only rarely did medical documentation become the focus of malpractice suits.

Developments in the mid-1970s, however, irrevocably affected the role of documentation in medicine. A dramatic national increase in medical malpractice claims and awards abruptly altered the strictly clinical nature of documentation. The patient medical record was swept into the broad realm of civil law. Since most medical liability suits approach resolution years after the contested care, the medical record provides a main source of information about what happened. The patient record became a legal document, a basis to reconstruct the quality and quantity of health care services. In many instances, it also serves as a physician's only defense against charges of malpractice.

Marked change in the Medicare program also served to broaden the influence of medical documentation during the 1970s. For example, the Centers for Medicare and Medicaid Services (CMS), Medicare's federal administrator, authorizes the program's regional carriers to review paid claims to determine whether the care was medically necessary, as mandated under the Social Security Act of 1996.

This type of review checks processed and paid claims against the documentation recorded at the time of service. The aim is to ensure that Medicare dollars are administered correctly and, once again, medical documentation must support the medical necessity of the service, to what extent the service was rendered, and why it was medically justified. For example, based on findings from a routine x-ray exam, a radiologist may believe further studies are warranted. Documentation must indicate the medical necessity for the added studies. In such a situation, the radiologist is not required to check with the ordering physician before proceeding. However, the service may require prior authorization from the payer, depending on payer guidelines.

Medicare does not pay for services that are "medically unnecessary,"according to Medicare standards. Patients are not liable to pay for such services if the service is performed without prior notification from the physician. Medical necessity requires items and services to be:

- Consistent with symptoms or diagnosis of disease or injury
- Necessary and consistent with generally accepted professional medical standards (e.g., not experimental or investigational)
- Furnished at the most appropriate level that can be provided safely and effectively to the patient

Computer conversion of the review process in the 1980s added a new twist: speed and a degree of accuracy. Claims adjudication, data analysis, and physician profiling revealed incongruities. A significant number of physicians and hospitals were found to have billed for services that were not provided or found to be medically unnecessary. Projected total estimates in the millions of dollars were publicized by CMS as findings of fraud and abuse. These findings led to the creation of the federal Fraud and Abuse program coordinated by several federal organizations, including the Department of Health and Human Services (HHS), and its agencies, CMS, and the Office of Inspector General (OIG). In 1997, CMS reported a possible $23 billion in questionable Medicare payments due to documentation problems in the hospital and outpatient settings.

Commercial insurance companies were quick to follow suit. Similar to CMS, private payers monitor claims to uncover coding mistakes and to verify that the documentation supports the claims submitted. Although there are no national guidelines for proper documentation, the guidelines this chapter provides should ensure better quality of care and increase the chances of full and fair reimbursement.

Methods of Documentation

The problem-oriented medical record (POMR) is one documentation method. The provider identifies problems individually and arranges them for resolution. The POMR has four elements: (1) database, (2) problem list, (3) initial plans, and (4) progress notes.

At minimum, the data portion of the POMR includes information such as chief complaint, present illness, past, present, family, and social history, review of systems, physical examination, and baseline ancillary data.

The problem list consists of any problem that requires management or diagnostic workup. It may be a symptom, an abnormal finding, a physiological finding, or a specific diagnosis. The provider adds or changes the list as problems are identified and resolved.

The third portion, initial plans, states what the provider plans to do to learn more about the problem, to treat it, and to educate the patient about the problem.

Progress notes are the final element of the POMR. Each problem is documented with regard to the following: (S)ubjective findings (symptoms); (O)bjective findings (measurable, observable); (A)ssessment (interpretation or impression of the current condition); and (P)lan (treatment). This process is often referred to by the acronym "SOAP."

The integrated medical record is another method of documentation that is strictly chronological without section divisions by the source of care. This keeps the episode of care documented in one continuous flow by date; but may make it more difficult to compare information from the same source, such as laboratory data. Because of this disadvantage, some chart order arrangements may integrate certain types of forms while maintaining others, such as radiology reports, together chronologically.

No specific format for documentation is recommended. It depends on the provider. But it is important that anyone reading the medical record be able to understand from the documentation the service rendered and the reason for the service.

General Guidelines for Documentation

Documentation is the recording of pertinent facts and observations about a patient's health history, including past and present illnesses, tests, treatments, and outcomes. The medical record documents the care of the patient to:

- Enable a physician or other health care professionals to plan and evaluate the patient's treatment
- Enhance communication and promote continuity of care among physicians and other health care professionals involved in the patient's care
- Facilitate claims review and payment
- Assist in utilization review and quality of care evaluations
- Reduce hassles related to medical review
- Provide clinical data for research and education
- Serve as a legal document to verify the care provided (e.g., as defense in the case of a professional liability claim)

Payers want to know that their health care dollars are well spent. Because they have a contractual obligation to beneficiaries, they look for the documentation to validate that services are:

- Appropriate for treating the patient's condition
- Medically necessary for the diagnosis
- Coded correctly

To ensure the appropriate reimbursement for services, the provider should use documentation to demonstrate compliance with any third-party payer utilization guidelines.

Principles of Documentation

To provide a basis for maintaining adequate medical record information, follow the principles of medical record documentation listed. The principles below have been developed by representatives of the following organizations:

- American Health Information Management Association (AHIMA)
- American Hospital Association (AHA)
- American Managed Care and Review Association (AMCRA)
- American Medical Association (AMA)
- American Medical Peer Review Association (AMPRA)
- Blue Cross and Blue Shield Association
- Health Insurance Association of America (HIAA)

Medical Record Documentation

- The medical record should be complete and legible.
- The documentation of each patient encounter should include the date, the reason for the encounter, appropriate history and physical exam, review of lab and x-ray data, and other ancillary services (where appropriate), an assessment, and a care plan (including discharge plan, if appropriate).
- Past and present diagnoses should be accessible to the treating or consulting health care professional.
- The reasons for and results of x-rays, lab tests, and other ancillary services should be documented and included in the medical record.
- Relevant health risk factors should be identified.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance, should be documented.
- The written plan for care should include treatments and medications—specifying frequency and dosage, any referrals and consultations, patient and family education, and specific instructions for follow-up.
- The documentation should support the intensity of the patient evaluation and the treatment, including thought processes and the complexity of medical decision making.
- All entries to the medical record should be dated and authenticated.
- The codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Documentation to Code and Bill

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve the medical necessity of care. Initial evaluation findings documenting the medical diagnosis form the basis for judging the reasonableness and necessity of care that was subsequently provided. Consequently, the

Claims Processing

The most important document for correct reimbursement is the insurance claim, whether it is submitted electronically or on a standardized paper claim form. Other information, such as operative reports, chart notes, and cover letters may establish medical necessity, but the claim "sets the stage."

The term "claims processing" describes the course of submitting a claim to the payer and subsequent adjudication. Understanding how this process works allows physicians and staff members to file claims properly and leads to maximum and timely reimbursement. In addition, this knowledge will allow the physician's office to serve as a resource to patients in understanding the process.

With commercial insurance companies, submit the claim directly to the payer or provide the patient with the necessary information to submit the claim. If there is a signed agreement with Blue Cross and Blue Shield or with an HMO or PPO, the office may be required to send the claim directly to the insurer. Medicare requires that the office submit all Medicare claims directly to the carrier, whether participating or not in the Medicare program.

If patients pay at the time of service, the office may want to provide an itemized statement or a superbill attached to a claim form that can be submitted to the patient's insurance company. This arrangement works well for office services, but surgical services are usually more accurately reimbursed if the office bills the hospital and surgical services directly to the payer.

For paper claims, use the standard claim forms (CMS-1500 and the UB-92 described in this chapter) when submitting charges, and be sure to complete the forms completely and accurately.

What to Include on Claims

Patient Information

Before filing any claim, obtain clear, accurate information from the patient, and update the information regularly. Most offices verify the information at each visit. A uniform policy for multiple physician offices or clinics makes everyone accountable for current and correct patient data.

Primary vs. Secondary Coverage

Households with dual incomes often have more than one insurer. Determine which is the primary and which is the secondary insurance company. For commercial plans, the subscriber's or insured's insurance company is always primary for the subscriber. In other words, the husband's insurance company is primary for him and the wife's insurance company is primary for her. However, the primary insurance company for any dependents is determined by the insureds' birthdays, the primary insured being the individual whose birthday is first during the year. This is often referred to as the "birthday rule." For example, if the husband's birthday is October 14, 1960 and the wife's birthday is March 1, 1962, the wife is primary for their dependents because her birthday is first during the year (year of birth is ignored).

Assignment of Benefits and Release of Information

Consider adding an assignment of benefits statement to the patient information form. It should state that the patient has agreed to have insurance payments sent directly to the physician and that medical information can be released to the patient's insurance company. A signed copy of this assignment submitted with a claim helps ensure at least partial payment from most commercial insurers. Assignments also reduce collection expenses. An alternative, lifetime assignment of benefits should nearly eliminate the need to obtain a signature after each date of service; however, there are payers that require a current signature with each claim.

If the office participates with Medicare, an assignment of benefits and release of billing are necessary.

Determining Coverage

A patient's insurance coverage should be verified before any service is rendered with the common sense exception of emergency treatment. This policy should not apply exclusively to new patients. Established patients may have changed employers, married or divorced, or no longer be covered by the same policy that was in effect during the last visit. The law requires Medicaid patients to provide current proof of eligibility with each visit.

Preauthorization

Determining in advance the benefits and allowables provides the physician's office with reimbursement figures before the patient's visit. Under most circumstances, the office should be able to discuss the deductible, copayment, and balance over and above the allowable with the patient prior to providing costly surgical services. Asking a few pointed questions of the patient and insurer will provide additional information regarding deductibles, for example:

- How much is the deductible and has it been met for the current year?
- What are the allowables for the quoted procedures?
- What percentage of the allowables will be paid?

Clean Claims

Claims submitted with all of the information necessary for processing are referred to as "clean" and are usually paid in a timely manner. Paying careful attention to what should appear on the claim form helps produce these clean claims. Common errors include the following:

- Failure to pay attention to communications from carriers (including Medicare and Medicaid transmittals)
- An incorrect patient identification number

- Patients' names and addresses that differ from the insurers' records
- Physician tax identification numbers, provider numbers, or Social Security numbers that are incorrect or missing
- No or insufficient information regarding primary or secondary coverage
- Missing authorized signatures — patient and/or physician
- Dates of service that are incorrect or don't coincide to the claims information sent by other providers (such as hospitals or nursing homes)
- Dates that lack the correct number of digits
- A fee column that is blank or not itemized and totaled
- Incomplete patient information
- Invalid CPT and ICD-9 codes, or diagnostic codes that are not linked to the correct services or procedures
- An illegible claim

The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) is a complex, multi-faceted law containing a number of provisions and amendments. It was passed as a means of improving the portability and availability of health insurance coverage for individuals and groups. While insurance reform (Title 1) is an important aspect of the law, it is the anti-fraud and abuse provisions that have the greatest impact on physician practices and daily operational activities. Other provisions promote the use of medical savings accounts, improving access to long-term care services and coverage, and simplification of health insurance administration.

Possibly the best approach is to be certain that your practice keeps abreast of the rapid changes taking place as the different provisions of HIPAA are implemented. One of the best sources of information is the CMS web site, which provides not only background information, but also keeps you up to date with current rules and CMS requirements. That address is http://www.cms.hhs.gov/hipaa

Administrative Simplification Provisions

The Administrative Simplification provisions of HIPAA (Title II) requires HHS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Implementation of these standards and encouraging the use of electronic data interchange (EDI) in health care will improve the efficiency of the nation's health care system, reduce the administrative burden on providers and health care plans, and save over $30 billion over the next decade.

Under HIPAA, every health care provider will be able to use EDI standards for billing and other health care transactions, such as referrals and diagnosis reports. All health plans will be required to accept these standard electronic claims, and all health care providers using electronic transmittals will be required to use the EDI standards. Providers that submit information by paper will not be affected by the rules. However, the health plans they bill are not prohibited from independently requiring the EDI standards for paper transactions as well.

Guidelines specify that transactions involving the following types of information exchanges between health care plans, clearinghouses, and providers are subject to EDI standards:

- Health care claims and equivalent encounter information
- Health care payment and remittance advices
- Coordination of benefits
- Health care claim status
- Enrollment or disenrollment in a health plan
- Eligibility for a health plan
- Referral certification and authorization
- Health insurance plan premiums

The claims standard mandated by HIPAA is the ASC X12N 837, which is designed to accommodate claims billing data electronically. Implementation guides are available from the Washington Publishing Company on their website at http://www.wpc-edi.com.HIPAA

The deadline for compliance with the electronic transactions rule was October 16, 2002, with the exception of small health plans (defined as those with less than $5 million in gross receipts) that have until October 2003. However, with passage of the Administrative Simplification Compliance Act (ASCA) in December, 2001, Congress authorized a one-year extension for entities that are required to comply as long as they submitted a compliance plan on or before October 15, 2002 that outlined how they would reach their goal of compliance within the year. The plan was required to include the following:

- Strategy, work plan, budget, and schedule for compliance implementation
- The entity's current compliance level and reasons why compliance could not be accomplished by the date of the original deadline
- Entity's plans with regards to obtaining outside help from a vendor or contractor
- A schedule for testing that began prior to April 16, 2003

Providers and other covered entities may use the model compliance plan that is available on the CMS web site at http://www.cms.hhs.gov/hipaa

Providers with no capability for electronic claim submission and those with less than 25 full-time employees (facilities) and 10 full-time employees (physician practices) are exempt from the requirement to submit claims electronically.

A health care provider electing to use direct data entry transactions approved by a health plan is required to use

CPT Definitions and Guidelines

Physicians' Current Procedural Terminology, Fourth Edition, (CPT®), is developed, published, and copyrighted by the American Medical Association (AMA) annually. CPT codes predominantly describe medical services and procedures performed by physicians and non-physician professionals. The codes are classified as Level I of the HCPCS coding system.

In general, whenever possible, providers should consider using CPT codes to describe their services for several reasons. Foremost, providers can evaluate patient care by reviewing the services and procedures coded. Secondly, procedural coding is a language understood in the provider and payer communities. Consequently, accurate coding can also help an insurer determine coverage eligibility for services provided.

Accurate coding consists of choosing the most appropriate code available for the service provided to the patient. However, the existence of a CPT or HCPCS code does not guarantee that a third-party payer will accept the code or that the service described by the code is covered.

Investigate codes that are denied or downcoded on a claim by the third-party payer, and resubmit with the correct codes if necessary.

Structure of CPT

The CPT coding system has an introduction, six main sections, five appendixes and an index.

Category I Codes

The sections considered Category I are:

- Evaluation and Management
- Anesthesia
- Surgery
- Radiology, Nuclear Medicine, and Diagnostic Ultrasound
- Pathology and Laboratory
- Medicine

Category II Codes

Category II codes, which are published January 1 and July 1 of each year, are supplemental tracking codes that are to be used for performance measurement only. They describe components usually included in an evaluation and management service or test results that are part of a laboratory test. Use of these codes is voluntary. However, they are not to be used in lieu of Category I codes.

Category III Codes

Category III codes, which are considered temporary, have been added for reporting the use of new technologies that are not available to report in the existing Category I CPT code set.

CPT Coding Conventions

To code properly, you must understand and follow the CPT conventions developed by the AMA.

Symbols

There are several symbols used in the CPT book.

- A bullet (●) before the code means that the code is new to the CPT coding system in the current year.
- A triangle (▲) before the code means that the code narrative has been revised in the current year.
- Codes with a (+) symbol indicate an "add-on" code. Procedures described by "add-on" codes are always performed in addition to the primary procedure and should never be reported alone. This concept applies only to procedures or services performed by the same physician to describe any additional intra-service work, such as a procedure on additional digits or lesions, associated with the primary procedure.
- This symbol (▶◀) indicates new or revised text other than that contained in the code descriptors.
- The symbol (⃠) designates a code that is exempt from the use of modifier 51 when multiple procedures are performed even though they have not been designated as "add-on" codes.
- Prior to 2004, the CPT book also contained a starred procedure designation (indicated by an asterisk after the code) that signified a surgical procedure considered by the American Medical Association (AMA) to be a minor surgical procedure that did not include pre- or postoperative services. This designation, which was not recognized for Medicare purposes, was eliminated in *CPT 2004*. Check with individual payers to determine their specific billing guidelines.

  The Centers for Medicare and Medicaid Services (CMS) has its own guidelines for what is a minor surgical procedure, as do many other payers. Medicare guidelines differ with regards to how payment is made. For instance, when a minor procedure involves an incision, it usually has a 10-day follow-up global period during which all visits are included in the fee for the original procedure.

Unlisted Procedures and Modifiers

Unlisted Procedures

Not all medical services or procedures are assigned CPT codes. The code book does not contain codes for infrequently used, new, or experimental procedures. Each code section contains codes set aside specifically for reporting unlisted procedures.

Before choosing an unlisted procedure code, carefully review the CPT code list to ensure that a more specific code is not available. Also, check for a HCPCS Level II code if these codes are acceptable to the third-party payer. These codes are found at the end of the section or subsection of codes and most often end in "99." For example:

90899 Unlisted psychiatric service or procedure

Whenever an unlisted code is reported, it is necessary to include a descriptive narrative of the procedure performed in item 19 of the CMS-1500 claim form, as long as it can be adequately explained in the space provided.

Payers generally require additional documentation (e.g., progress notes, operative notes, consultation report, or history and physical) before considering claims with unlisted procedure codes.

Modifiers

The CPT coding system also includes modifiers that can be added to codes to describe extenuating or special circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Addition of the modifier does not alter the basic description for the service; it merely qualifies the circumstances under which the service was provided. Some third-party payers, such as Medicare, require modifier use in some circumstances. Circumstances that modify a service include the following:

- Procedures have both a technical and professional component
- More than one individual or setting was involved in the service
- Only part of a service was performed
- The service was delivered to more than one patient
- Adjunctive, complex or bilateral procedures were performed

The following CPT modifiers are used most often by Behavioral Health Providers:

21 **Prolonged Evaluation and Management Services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21.

22 **Unusual Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22. A report may also be appropriate.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:** The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

26 **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the procedure code.

32 **Mandated Services:** Services related to mandated consultation and/or related services (eg, PRO, 3rd party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 **Multiple Procedures:** When multiple procedures, other than Evaluation and Management Services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated "add-on" codes.

52 **Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 **Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of

CPT Index

ICD-9-CM Definitions and Guidelines

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), is a classification system in which diseases and injuries are arranged in groups of related cases for statistical purposes. Based on the World Health Organization's (WHO) International Classification of Diseases, the ICD system has been revised periodically to meet the needs of statistical data usage. In the United States, the system has been expanded and clinically modified (-CM) to meet unique clinical purposes. Clinical uses include indexing medical records, facilitating medical care reviews, and completing reimbursement claims.

The responsibility for maintenance of the classification system is shared between the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS). These two organizations co-chair the ICD-9-CM Coordination and Maintenance Committee, which meets twice a year in a public forum to discuss revisions to the classification system. Final decisions concerning any revisions to the system are made by the director of NCHS and the administrator of CMS. Once determined, the final decisions are published in the *Federal Register* and become effective October 1 of each year.

The ICD-9-CM coding system is a method of translating medical terminology for diseases and procedures into codes. Codes within the system are either numeric or alphanumeric and are made up of three, four, or five characters. A decimal point follows all three-character codes when fourth and fifth digits are required. "Coding" involves using a numeric or alphanumeric codes to describe a disease or injury. For example, depression with anxiety is translated into code 300.4.

Although hospitals and other health care facilities have used ICD-9-CM codes for many years, health care provider offices are also required to use ICD-9-CM codes for all Medicare billings. Thus, it is essential that coding staff, regardless of setting, become more knowledgeable, proficient, and accurate in their use of the ICD-9-CM diagnosis coding system. By improving coding skills, appropriate reimbursement, and efficient claims processing, coders limit audit liability and decrease the number of denied claims and requests for additional information.

This chapter provides information on the structure of ICD-9-CM. We have also identified coding tips and guidelines that are pertinent to the behavioral health care provider.

Coding Tip

Be sure that your ICD-9-CM coding system contains the most up-to-date information available. Changes take place October 1 of every year, and your code book must be current to ensure accurate coding.

The Structure of ICD-9-CM

The ICD-9-CM system contains two classifications, one for diseases and the other for procedures. It consists of three volumes:

- **Volume 1, Diseases:** Tabular List
- **Volume 2, Diseases:** Alphabetic Index
- **Volume 3, Procedures:** Tabular List and Alphabetic Index

Volume 3, Procedures, is used primarily for inpatient coding. The physician office, outpatient clinics, or ambulatory surgery centers coding staff should use the CPT system for coding procedures. Therefore, only Volume 1 (Tabular List) and Volume 2 (Alphabetic Index) of ICD-9-CM are used in the physician office for assigning diagnosis codes. For this publication only the behavioral health services entries are listed.

The Structure of the Alphabetic Index

The Alphabetic Index of ICD-9-CM, commonly referred to as the Index, is used in the first step in assigning a code. The Index is divided into three sections: the "Alphabetic Index to Disease and Injury," the "Table of Drugs and Chemicals," and the "Alphabetic Index to External Causes of Injury and Poisoning." For this book, behavioral and mental health related index entries are listed.

Alphabetic Index to Diseases and Injuries

Included in this section is an alphabetic list of diseases, injuries, symptoms, and other reasons for contact with the physician. This section also contains two tables that classify hypertension and neoplasms.

Table of Drugs and Chemicals

The drugs and chemicals that are the external causes of poisoning and other adverse effects are organized in table format. Specific drugs and chemical substances that the patient may have taken, or been given, are listed alphabetically. Each of these substances is assigned a code to identify the drug as a poisoning agent, resulting from incorrect substances given, incorrect dosages taken, overdose, or intoxication. The five columns titled, "External Cause," list E codes for external causes depending upon if the circumstances involved in the use of the drug were accidental, for therapeutic use, a suicide attempt, an assault, or undetermined.

Alphabetic Index to External Causes of Injury and Poisoning (E Codes)

This section is an alphabetic list of environmental events, circumstances, and other conditions that can cause injury and adverse effects.

The Structure of the Tabular List

The Tabular List contains codes and their narrative descriptions. There are three sections: the Classification of Disease and Injuries, Supplementary Classifications, and the Appendices.

Section 1: Classification of Diseases and Injuries

The first section of the Tabular List contains 17 chapters. Ten chapters are devoted to major body systems. The other seven chapters describe specific types of conditions that affect the entire body. This classification contains only numeric codes, from 001.0 to 999.9.

Chapter	Chapter Title	Category Code Range
1.	Infectious and Parasitic Diseases	001–139
2.	Neoplasms	140–239
3.	Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	240–279
4.	Diseases of the Blood and Blood forming Organs	280–289
5.	Mental Disorders	290–319
6.	Diseases of the Nervous System and Sense Organs	320–389
7.	Diseases of the Circulatory System	390–459
8.	Diseases of the Respiratory System	460–519
9.	Diseases of the Digestive System	520–579
10.	Diseases of the Genitourinary System	580–629
11.	Complications of Pregnancy, Childbirth and the Puerperium	630–677
12.	Diseases of the Skin and Subcutaneous Tissue	680–709
13.	Diseases of the Musculoskeletal System and Connective Tissue	710–739
14.	Congenital Anomalies	740–759
15.	Certain Conditions Originating in the Perinatal Period	760–779
16.	Symptoms, Signs and Conditions	780–799
17.	Injury and Poisoning	800–999

Each of the 17 chapters in the Classification of Diseases and Injuries is divided into the following:

Subchapters. Subchapters are a group of closely related conditions. Separate titles describe the contents of each subchapter.

Category—Three-digit codes. Three-digit codes and their titles are called "category codes." Some three-digit codes are very specific and are not subdivided. These three-digit codes can stand alone to describe the condition being coded.

Subcategory—Four-digit codes. Most three-digit categories have been further subdivided with the addition of a decimal point followed by another digit. The fourth digit provides specificity or more information regarding such things as etiology, site, and manifestation. Four-digit codes are referred to as "subcategory codes" and take precedence over three-digit category codes.

Subclassification—Five-digit codes. Greater specificity has been added to the ICD-9-CM system with the expansion of four-digit subcategories to the fifth-digit subclassification level. Five-digit codes are the most precise subdivisions in the ICD-9-CM system.

Section 2: Supplementary Classifications (V Codes and E Codes)

Classification of Factors Influencing Health Status and Contact with Health Services (V Codes). The codes in this classification, otherwise known as V codes, are alphanumeric and begin with the letter "V." These codes are used to describe circumstances, other than a disease or injury, that are the reason for an encounter with the health care delivery system or that have an influence on the patient's current condition.

Example

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

V codes are sequenced depending on the circumstance or problem being coded. Some V codes are sequenced first to describe the reason for the encounter, while others are sequenced second because they identify a circumstance that affects the patient's health status but is not in itself a current illness. Assignment of V codes will be discussed in depth in a separate section.

Classification of External Causes of Injury and Poisoning (E Codes). These codes are also alphanumeric and begin with the letter "E." They are used to describe circumstances and conditions that cause injury, poisoning, or other adverse side effects. They may be used in addition to codes in the main classification (001-999) to identify the external cause of an injury or condition. They may never be used alone and may never be listed as the first diagnosis.

Example

821.01 Right femur shaft fracture

E814.7 Pedestrian struck by motorcycle

Section 3: Appendices

Appendix A: Morphology of Neoplasms. This appendix is an adaptation of the International Classification of Diseases for Oncology (ICD-O), a coded nomenclature of the morphology of neoplasms. These codes are alphanumeric and begin with the letter "M." An example is code M8000/0, Neoplasm, benign.

Appendix B: Glossary of Mental Disorders. This glossary consists of psychiatric terms that are used in ICD-9-CM chapter 5, titled "Mental Disorders." This glossary can be used to ensure that their terminology is consistent with the ICD-9-CM coding system.

ICD-9-CM Index

The ICD-9-CM chapter contains comprehensive information about the most frequently diagnosed conditions that require behavioral health services. This book is based on official Centers for Medicare and Medicaid Services (CMS) material and uses the most up-to-date diagnosis coding information available.

This chapter is meant only as a quick reference for behavioral health diagnoses. It does not replace Ingenix ICD-9-CM code books.

Physicians and hospitals are required by law to submit diagnosis codes for Medicare reimbursement. A passage in the Medicare Catastrophic Coverage Act of 1988 requires health care offices to include appropriate diagnosis codes when billing for services provided to Medicare beneficiaries on or after April 1, 1989. The repeal of the Act has not changed this requirement. CMS designated ICD-9-CM as the coding system physicians must use.

This chapter concentrates on the most common diagnoses that require behavioral health services. Easy to use, it contains an alphabetic list of diagnoses, and has symbols (see the symbol key) to identify common coding principles. Understanding these principles will increase the efficiency and promptness of claim submission for Medicare and other third-party payers.

Codes effective October 1, 2003 to September 30, 2004

ICD-9-CM Coding Conventions

The ICD-9-CM coding conventions, or rules, used in this book are outlined below. All ICD-9-CM coding rules can be found in the front of any ICD-9-CM code book.

The symbol 5th is used to indicate when a fifth-digit subclassification is required to complete a code. This symbol refers the coder to corresponding boxed information that defines the appropriate fifth digits.

Modifiers

The physician's diagnostic statement usually contains several medical terms. To translate the terms into diagnosis codes, choose only the condition as the main term. The other terms may be considered modifiers.

There are two types of modifiers, nonessential and essential:

Nonessential modifiers are shown in parentheses after the term they modify. Nonessential modifiers may be either present or absent in the diagnostic or procedure statement without affecting the code selection. These modifiers do not affect the code selection.

Essential modifiers are indented under the main term. When there is only one essential modifier, it is listed next to the main term after a comma. Essential modifiers affect code assignment; therefore, they should be used in the coding process only if they are specified in the physician's diagnosis.

In the following example, "anterior," "meatal," "organic," "posterior," and "spasmodic" are nonessential modifiers, and "urethra" is an essential modifier.

Stricture (see also Stenosis) 799.8
urethra (anterior) (meatal) (organic) (posterior) (spasmodic) 598.9 ▽

Cross-References

Cross-references make locating a code easier. Two types of cross-references are used in this book: see and see also.

The "see" cross-reference directs the coder to look for another term elsewhere in the book. For example:

Tumor
dermois — *see* Neoplasm, by site, benign

The "see also" cross-reference provides the coder with an alternative main term if the appropriate description is not found under the initial main term, such as:

Stricture (*see also* Stenosis) 799.8
urethra (anterior) (meatal) (organic) (posterior) (spasmodic) 598.9 ▽

Abbreviations

NEC — "Not elsewhere classifiable." Not every condition has its own ICD-9-CM code. The NEC abbreviation is used with those categories of codes for which a more specific code is not available. The NEC code describes all other specified forms of a condition. For example:

Disorder (*see also* Disease)
bone NEC 733.90 ▽

NOS — "Not otherwise specified." Coders should use an NOS code only when they lack the information necessary for assigning a more specific code.

Manifestation Codes

As in the following example, when two codes are required to indicate etiology and manifestation, the manifestation code appears in italics and brackets. The manifestation code is never a principal/primary diagnosis. Etiology is always sequenced first.

Arthritis, arthritic (acute) (chronic)
due to or associated
with enteritis NEC 009.1 *[711.3]*

Official ICD-9-CM Guidelines for Coding and Reporting

The Public Health Service and CMS of the U.S. Department of Health and Human Services (DHHS) present the following guidelines for coding and reporting using ICD-9-CM. These guidelines should be used as a companion document to the official versions of the ICD-9-CM.

These guidelines for coding and reporting have been developed and approved by the cooperating parties for ICD-9-CM: American Hospital Association, American Health Information Management Association, and the National Center for Health Statistics. These guidelines appear in the second quarter 2002 *Coding Clinic for*

ICD-9-CM, published by the American Hospital Association, where they are updated regularly.

These guidelines have been developed to assist the user in coding and reporting in situations where the ICD-9-CM book does not provide direction. Coding and sequencing instruction in the three ICD-9-CM volumes take precedence over any guidelines.

These guidelines are not exhaustive. The cooperating parties are continuing to conduct review of these guidelines and to develop new guidelines as needed. Users of ICD-9-CM should be aware that only guidelines approved by the cooperating parties are official. Revisions of these guidelines and new guidelines will be published by the DHHS when they are approved by the cooperating parties.

Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office)

These coding guidelines for outpatient diagnoses have been approved for use by hospitals and physicians in coding and reporting hospital-based outpatient services and physician office visits.

The terms "encounter" and "visit" are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and physician reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that: 1) the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, general hospitals, and 2) coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term "first-listed diagnosis" is used in lieu of principal diagnosis.

In determining the first-listed diagnosis, the coding conventions of ICD-9-CM, as well as the general and disease-specific guidelines, take precedence over the outpatient guidelines. Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

B. The appropriate code or codes from 001.0 through V83.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

D. The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

E. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined Conditions (codes 780.0–799.9) contains many, but not all, codes for symptoms.

F. ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0–V83.89) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

G. Level of detail in coding

- ICD-9-CM is composed of codes with either three, four, or five digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits which provide greater specificity.
- A three-digit code is to be used only if it is not further subdivided. Where four-digit subcategories and/or five-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.

H. List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.

I. Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis." Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by hospital medical record departments for coding the diagnosis of acute-care, short-term hospital inpatients.

HCPCS Level II Definitions and Guidelines

Introduction

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services and supplies. To be well versed in reimbursement practices, coders should be familiar not only with the CPT coding system (HCPCS Level I) but also with HCPCS Level II codes which are becoming increasingly important to reimbursement as they are extended to a wider array of medical services.

HCPCS Level II—National Codes

Level II codes commonly are referred to as national codes or by the acronym HCPCS (Health Care Common Procedure Coding System (pronounced hik piks). HCPCS codes are used for billing Medicare and Medicaid patients and have been adopted by some third-party payers.

These codes, updated and published annually by CMS, are intended to supplement the CPT coding system (Level I) by including codes for nonphysician services, administration of injectable drugs, durable medical equipment, and office supplies.

When using HCPCS Level II codes, keep the following in mind:

- CMS does not use consistent terminology for unlisted services or procedures. The code descriptions may include any one of the following terms: "unlisted," "not otherwise classified (NOC)," "unspecified," "unclassified," "other," and "miscellaneous."
- If billing for specific supplies and materials, avoid CPT code 99070 (general supplies) and be as specific as possible unless the local carrier directs otherwise.
- Coding and billing should be based on the service provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage references (*Coverage Issues Manual* and *Medicare Coverage Manual*) to determine whether the care provided is a covered service.
- When both a CPT and HCPCS Level II code share nearly identical narratives, apply the CPT code. If the narratives are not identical, select the code with the narrative that better describes the service. Generally, the HCPCS Level II code is more specific and takes precedence over the CPT code.

Level III—Local Codes

All HCPCS level III local codes have been recently phased out, a process that began in 2002. As the first step, effective October 16, 2002, carriers were required to eliminate all local codes and modifiers that had not been approved by CMS. Carriers had to identify those codes and modifiers in use, crosswalk them to national codes and delete any that were not approved. If carriers felt that an unapproved code should be retained for use, they had to submit a request for a temporary national code for that service/supply, with an explanation as to why the code should be kept. These requests were due to their regional office by April 1, 2002.

The next phase was the elimination of the official HCPCS Level III local codes and modifiers by December 31, 2003. Again, carriers were required to review all local codes in their systems, crosswalk them to appropriate national codes and submit requests for replacement temporary national codes by April 1, 2003. Temporary national codes that are requested and approved will be implemented January 1, 2004.

Local codes had been used to denote new procedures or specific supplies for which there was no national code. For Medicare, these five-digit alphanumeric codes use the letters W through Z. Each carrier may create local codes as the need dictates. However, carriers were required to obtain approval from CMS's central office before implementing them. The Medicare carrier was responsible for providing you with these codes.

Due to the Consolidated Appropriations Act of 2001, and as part of the National Code Data Sets implemented under the Health Insurance Portability Accountability Act, the Secretary of Health and Human Services was instructed to maintain and continue the use of HCPCS level III codes through December 31, 2003.

Program Memorandum (PM) AB-01-45 instructed Carriers to take the following steps to implement the law on April 29th, 2001:

- Maintain and accept current level III HCPCS codes and or modifiers until December 31, 2003. However, Carriers were not allowed to create any new HCPCS Level III codes and or modifiers.
- Carriers were to reinstate any HCPCS level III codes and/or modifiers they may have eliminated after August 16, 2000.
- Carriers were to publish on their websites any HCPCS level III and modifiers with their descriptors that were in effect August 16, 2000.

Medicare carriers who wished to establish a temporary national code had to submit the request to their regional office. The regional office then submitted that recommendation to the central office for approval.

Structure and Use of HCPCS Level II Codes

The Index

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures. Where possible, entries are listed under a "common" main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

Searching the Index

The steps to follow for searching the index are:

1. Analyze the statement or description provided that designates the item to be coded.
2. Identify the main term.
3. Locate the main term in the index.
4. Check for relevant subterms under the main term. Verify the meaning of any unfamiliar abbreviations.
5. Note the codes found after the selected main term or subterm.
6. Locate the code in the alphanumeric list to ensure the specificity of the code. If a code range is provided, locate the code range and review all code narratives in that code range for specificity.

In some cases, an entry may be listed under more than one main term.

Never code directly from the index. Always verify the code choice in the alphanumeric list and the index.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

The HCPCS coding system is arranged in 17 sections:

A codes	A0021–A9999	Transportation Services, Including Ambulance, Chiropractic Services, Medical and Surgical Supplies and Miscellaneous and Investigational
B codes	B4034–B9999	Enteral and Parenteral Therapy
C codes	C1000–C9999	Temporary Codes for use with Outpatient PPS
D codes	D0120–D9999	Dental Procedures
E codes	E0100–E9999	Durable Medical Equipment
G codes	G0001–G9999	Temporary Procedures/ Professional Services
H codes	H0001–H9999	Alcohol and Drug Abuse Treatment Services
J codes	J0120–J9999	Drugs Administered Including Oral and Chemotherapy Drugs
K codes	K0001–K9999	Durable Medical Equipment Prosthetics, Orthotics, Supplies and Dressings (DMEPOS)
L codes	L0100–L9999	Orthotic and Prosthetic Procedures, Devices
M codes	M0064–M9999	Medical Services
P codes	P2028–P9999	Pathology and Laboratory Services
Q codes	Q0035–Q9999	Miscellaneous Services (Temporary Codes)
R codes	R0070–R9999	Radiology Services
T codes	T1000–T9999	Medical Services
S codes	S0009–S9999	Commercial Payers (Temporary Codes)
V codes	V2020–V9999	Vision, Hearing and Speech-Language Pathology Services

Section Guidelines

Examine the instructions found at the beginning of each of the 17 sections. Instructions include the guidelines, notes, unlisted procedures, special reports, and the modifiers that pertain to each section.

Use the alphabetic index to initially locate a code by looking for the type of service or procedure performed. The same rule applies: never code directly from the index. Always check the specific code in the appropriate section.

The Conventions: Symbols and Modifiers

Symbols

Symbols used in the HCPCS Level II system may be presented in various ways, depending on the vendor. Ingenix follows the pattern established by the AMA in the CPT code books. For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

Example

● **H2034 Alcohol and/or drug abuse halfway house services, per diem**

A triangle (▲) is used (as in the CPT system) to indicate that a change in the narrative of a code has been made from the previous year's edition. The change made may be slight or significant, but it usually changes the application of the code.

Example

▲ **S0316 Follow-up/reassessment**

Modifiers

In certain circumstances, modifiers must be used to report the alteration of a procedure or service. In HCPCS Level I, modifiers are two-digit suffixes that usually directly follow the five-digit procedure or service code.

In HCPCS Level II, modifiers are composed of two alpha or alphanumeric characters that range from AA to VP:

HCPCS Level II Index

Medicare Official Regulatory Information*

Revisions to the CMS Manual System

The Centers for Medicare and Medicaid Services (CMS) initiated its long awaited transition from a paper-based manual system to a Web-based system on October 1, 2003, which updates and restructures all manual instructions. The new system, called the online CMS Manual system, combines all of the various program instructions into an electronic manual, which can be found at http://www.cms.hhs.gov/manuals.

Effective September 30, 2003, the former method of publishing program memoranda (PMs) to communicate program instructions was replaced by the following four templates:

- One-time notification
- Manual revisions
- Business requirement
- Confidential requirements

The Office of Strategic Operations and Regulatory Affairs (OSORA), Division of Issuances, will continue to communicate advanced program instructions to the regions and contractor community every Friday as it currently does. These instructions will also contain a transmittal sheet to identify changes pertaining to a specific manual, requirement, or notification.

The Web-based system has been organized by functional area (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity) in an effort to eliminate redundancy within the manuals, simplify the updating process, and make CMS program instructions available in a more timely manner. The initial release will include Pub. 100, Pub. 100-02, Pub. 100-03, Pub. 100-04, Pub. 100-05, Pub. 100-09, Pub. 100-15, and Pub. 100-20.

The Web-based system contains the functional areas included in the table below:

Publication #	Title
Pub. 100	Introduction
Pub. 100-1	Medicare General Information, Eligibility, and Entitlement
Pub. 100-2	Medicare Benefit Policy (basic coverage rules)
Pub. 100-3	Medicare National Coverage Determinations (national coverage decisions)
Pub. 100-4	Medicare Claims Processing (includes appeals, contractor interface with CWF, and MSN)
Pub. 100-5	Medicare Secondary Payer
Pub. 100-6	Medicare Financial Management (includes Intermediary Desk Review and Audit)
Pub. 100-7	Medicare State Operations (The new manual is under development. Please continue to use the paper-based manual.)
Pub. 100-8	Medicare Program Integrity
Pub. 100-9	Medicare Contractor Beneficiary and Provider Communications
Pub. 100-10	Medicare Quality Improvement Organization
Pub. 100-11	Reserved
Pub. 100-12	State Medicaid (The new manual is under development. Please continue to use the paper-based manual.)
Pub. 100-13	Medicaid State Children's Health Insurance Program (Under development)
Pub. 100-14	Medicare End Stage Renal Disease Network
Pub. 100-15	Medicare State Buy-In
Pub. 100-16	Medicare Managed Care
Pub. 100-17	Medicare Business Partners Systems Security
Pub. 100-18	Medicare Business Partners Security Oversight
Pub. 100-19	Demonstrations
Pub. 100-20	One-Time Notification

Table of Contents

The table below shows the paper-based manuals used to construct the Web-based system. Although this is just an overview, CMS is in the process of developing detailed crosswalks to guide you from a specific section of the old manuals to the appropriate area of the new manual, as well as to show how the information in each section was derived.

Paper-Based Manuals	Internet-Only Manuals
Pub. 06–Medicare Coverage Issues	Pub. 100-01–Medicare General Information, Eligibility, and Entitlement
Pub. 09–Medicare Outpatient Physical Therapy	
Pub. 10–Medicare Hospital	Pub. 100-02–Medicare Benefit Policy
Pub. 11–Medicare Home Health Agency	Pub. 100-03–Medicare National Coverage Determinations
Pub. 12–Medicare Skilled Nursing Facility	
Pub. 13–Medicare Intermediary Manual, Parts 1, 2, 3, and 4	Pub. 100-04–Medicare Claims Processing
Pub. 14–Medicare Carriers Manual, Parts 1, 2, 3, and 4	Pub. 100-05–Medicare Secondary Payer

**Medicare Carriers Manual (MCM) and Coverage Issues Manual (CIM) sections are printed verbatim from these manuals and current at the time of printing of this publication. These references may be changed by CMS at any time thoughout the year.*

Paper-Based Manuals	Internet-Only Manuals
Pub. 21–Medicare Hospice	Pub. 100-06–Medicare Financial Management
Pub. 27–Medicare Rural Health Clinic and Federally Qualified Health Center	Pub. 100-08–Medicare Program Integrity
Pub. 29–Medicare Renal Dialysis Facility	Pub. 100-09–Medicare Contractor

Beneficiary and Provider Communications

Paper-Based Manuals	Internet-Only Manuals
Pub. 19–Medicare Peer Review Organization	Pub. 100-10–Medicare Quality Improvement Organization
Pub. 07–Medicare State Operations	Pub. 100-07–Medicare State Operations
Pub. 45–State Medicaid	Pub. 100-12–State Medicaid
	Pub. 100-13–Medicaid State Children's Health Insurance Program
Pub. 81–Medicare End Stage Renal Disease Renal Disease Network Organizations	Pub. 100-14–Medicare End Stage Network Organizations
Pub. 24–Medicare State Buy-In	Pub. 100-15–Medicare State Buy-In
Pub. 75–Health Maintenance Organization/Competitive Medical Plan	Pub. 100-16–Medicare Managed Care
Pub. 76–Health Maintenance Organization/Competitive Medical Plan (PM)	
Pub. 77–Manual for Federally Qualified Health Maintenance Organizations	
Pub. 13–Medicare Intermediaries Manual, Part 2	Pub. 100-17–Business Partners Systems Security
Pub. 14–Medicare Carriers Manual, Part 2	
Pub. 13–Medicare Intermediaries Manual, Part 2	Pub. 100-18–Business Partners Security Oversight
Pub. 14–Medicare Carriers Manual, Part 2	
Demonstrations (PMs)	Pub 100-19–Demonstrations
Program instructions that impact multiple manuals or have no manual impact.	Pub 100-20–One-Time Notification

Program Memoranda

Pub. 60A–Intermediaries
Pub. 60B–Carriers
Pub. 60AB–Intermediaries/Carriers

NOTE: Information derived from Pub. 06 to Pub. 60AB was used to develop Pub. 100-01 to Pub. 100-09 for the Internet-only manual.

National Coverage Determinations Manual

The National Coverage Determinations Manual (NCD), which is the electronic replacement for the Coverage Issues Manual (CIM), is organized according to categories such as diagnostic services, supplies, and medical procedures. The table of contents lists each category and subject within that category. A revision transmittal sheet will identify any new material and recap the changes as well as provide an effective date for the change and any background information. At any time, one can refer to a transmittal indicated on the page of the manual to view this information.

By the time it is complete, the book will contain two chapters. Chapter 1 includes a description of national coverage determinations that have been made by CMS. When available, chapter 2 will contain a list of HCPCS codes related to each coverage determination. To make the manual easier to use, it is organized in accordance with CPT category sequences. Where there is no national coverage determination that affects a particular CPT category, the category is listed as reserved in the table of contents.

Medicare Benefit Policy Manual

The Medicare Benefit Policy Manual replaces current Medicare general coverage instructions that are not national coverage determinations. As a general rule, in the past these instructions have been found in chapter II of the Medicare Carriers Manual, the Medicare Intermediary Manual, other provider manuals, and program memoranda. New instructions will be published in this manual. As new transmittals are included they will be identified.

On the CMS Web site, a crosswalk from the new manual to the source manual is provided with each chapter and may be accessed from the chapter table of contents. In addition, the crosswalk for each section is shown immediately under the section heading.

The list below is the table of contents for the Medicare Benefit Policy Manual:

Chapter	Title
One	Inpatient Hospital Services
Two	Inpatient Psychiatric Hospital Services
Three	Duration of Covered Inpatient Services
Four	Inpatient Psychiatric Benefit Days Reduction and Lifetime Limitation
Five	Lifetime Reserve Days
Six	Hospital Services Covered Under Part B
Seven	Home Health Services
Eight	Coverage of Extended Care (SNF) Services Under Hospital Insurance
Nine	Coverage of Hospice Services Under Hospital Insurance
Ten	Ambulance Services
Eleven	End Stage Renal Disease (ESRD)
Twelve	Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

Glossary

The 72-hour Rule. Coding regulations are at the forefront of most health care fraud and abuse investigations. One such regulation, the 72-hour rule, targets billing procedures for outpatient diagnostic services occurring within 72 hours of a patient's admission to a hospital. For example, if lab tests are performed during the three days before a patient enters the hospital, those tests must be billed as if they were ordered while the patient was in the hospital. Violating this rule results in a duplicate billing, since pre-admission outpatient diagnostic services are legally considered part of the inpatient payment.

Aberrant. A deviation or wandering from the normal or usual course, condition, or pattern.

Abstractor. A person who selects and extracts specific data from the medical record and enters the information into computer files. The data and coded diagnoses track morbidity and mortality, infectious disease, and index disease. Information may be gathered to track data for departments such as quality assurance and utilization review within the facility.

Abuse. As defined by Medicare, an incident that is inconsistent with accepted sound medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or reimbursement for services that do not meet professionally recognized standards of care or which are medically unnecessary. Examples of abuse include excessive charges, improper billing practices, billing Medicare as the primary insurance instead of other third-party payers that are primary, and increasing charges for Medicare beneficiaries, but not to other patients.

Academic underachievement disorder. Failure to achieve in most school tasks despite adequate intellectual capacity, a supportive and encouraging social environment, and apparent effort. The failure occurs in the absence of a demonstrable specific learning disability and is caused by emotional conflict not clearly associated with any other mental disorder.

Accredited Record Technician (ART). A former certification title awarded to medical records practitioners; now known as a Registered Health Information Technician (RHIT).

Activities of daily living. Activities often used to determine eligibility for long-term care. They include bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

Adaptation reaction. see Adjustment reaction

Add-on codes. A procedure performed in addition to the primary procedure and designated with a "+" in CPT. Add-on codes are never reported as stand-alone services. They are reported secondarily in addition to the primary procedure.

Admission date. Date that the patient was admitted to the health care facility for inpatient care, outpatient service, or the start of care. This date is reported in UB-92 FL 17.

Adjudication. The process of hearing and settling a case through an objective, judicial procedure. In claims processing, the process of judging claims as payable, partially payable, or rejected.

Adjusted average per capita cost (AAPCC). This is the estimated average cost of Medicare benefits for an individual, based on the following criteria: age, sex, institutional status, Medicaid, disability, and end stage renal failure. CMS uses AAPCC as a guide to make monthly payments to risk and cost contractors.

Adjustment reaction or disorder. Mild or transient disorders lasting longer than acute stress reactions which occur in individuals of any age without any apparent pre-existing mental disorder. Such disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and content to stresses such as bereavement, migration, or other experiences. Reactions to major stress that last longer than a few days are also included. In children such disorders are associated with no significant distortion of development.

- **conduct disturbance –** Mild or transient disorders in which the main disturbance predominantly involves a disturbance of conduct (e.g., an adolescent grief reaction resulting in aggressive or antisocial disorder).
- **depressive reaction –** States of depression, not specifiable as manic-depressive, psychotic, or neurotic.
  - **brief –** Generally transient, in which the depressive symptoms are usually closely related in time and content to some stressful event.
  - **prolonged –** Generally long-lasting, usually developing in association with prolonged exposure to a stressful situation.
- **emotional disturbance –** An adjustment disorder in which the main symptoms are emotional in type (e.g., anxiety, fear, worry) but not specifically depressive.
- **mixed conduct and emotional disturbance –** An adjustment reaction in which both emotional disturbance and disturbance of conduct are prominent features.

Affective psychoses. Mental disorders, usually recurrent, in which there is a severe disturbance of mood (mostly compounded of depression and anxiety but also manifested as elation, and excitement) which is accompanied by one or more of the following – delusions, perplexity, disturbed attitude to self, disorder of perception and behavior; these

are all in keeping with the individual's prevailing mood (as are hallucinations when they occur). There is a strong tendency to suicide. For practical reasons, mild disorders of mood may also be included here if the symptoms match closely the descriptions given; this applies particularly to mild hypomania.

bipolar – A manic-depressive psychosis which has appeared in both the depressive and manic form, either alternating or separated by an interval of normality.

atypical – An episode of affective psychosis with some, but not all, of the features of the one form of the disorder in individuals who have had a previous episode of the other form of the disorder.

depressed – A manic-depressive psychosis, circular type, in which the depressive form is currently present.

manic – A manic-depressive psychosis, circular type, in which the manic form is currently present.

mixed – A manic-depressive psychosis, circular type, in which both manic and depressive symptoms are present at the same time.

depressed type – A manic-depressive psychosis in which there is a widespread depressed mood of gloom and wretchedness with some degree of anxiety. There is often reduced activity but there may be restlessness and agitation. There is marked tendency to recurrence; in a few cases this may be at regular intervals.

atypical – An affective depressive disorder that cannot be classified as a manic-depressive psychosis, depressed type, or chronic depressive personality disorder, or as an adjustment disorder.

manic type – A manic-depressive psychosis characterized by states of elation or excitement out of keeping with the individual's circumstances and varying from enhanced liveliness (hypomania) to violent, almost uncontrollable, excitement. Aggression and anger, flight of ideas, distractibility, impaired judgment, and grandiose ideas are common.

mixed type – Manic-depressive psychosis syndromes corresponding to both the manic and depressed types, but which for other reasons cannot be classified more specifically.

Aggressive personality. see Personality disorder, explosive type

Agoraphobia. see agoraphobia under Phobia

Alcohol dependence syndrome. A state, psychic and usually also physical, resulting from taking alcohol, characterized by behavioral and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present. A person may be dependent on alcohol and other drugs; if so, also record the diagnosis of drug dependence to identify the agent. If alcohol dependence is associated with alcoholic psychosis or with physical complications, both diagnoses should be recorded.

Alcohol intoxication

acute – A psychic and physical state resulting from alcohol ingestion characterized by slurred speech, unsteady gait, poor coordination, flushed facies, nystagmus, sluggish reflexes, fetor alcoholica, loud speech, emotional instability (e.g., jollity followed by lugubriousness), excessive conviviality, loquacity, and poorly inhibited sexual and aggressive behavior.

idiosyncratic – Acute psychotic episodes induced by relatively small amounts of alcohol. These are regarded as individual idiosyncratic reactions to alcohol, not due to excessive consumption and without conspicuous neurological signs of intoxication.

pathological – see Alcohol intoxication, idiosyncratic

Alcoholic psychoses. Organic psychotic states due mainly to excessive consumption of alcohol; defects of nutrition are thought to play an important role.

alcohol abstinence syndrome – see alcohol withdrawal syndrome below

alcohol amnestic syndrome – A syndrome of prominent and lasting reduction of memory span, including striking loss of recent memory, disordered time appreciation and confabulation, occurring in alcoholics as the sequel to an acute alcoholic psychosis (especially delirium tremens) or, more rarely, in the course of chronic alcoholism. It is usually accompanied by peripheral neuritis and may be associated with Wernicke's encephalopathy.

alcohol withdrawal delirium [delirium tremens] – Acute or subacute organic psychotic states in alcoholics, characterized by clouded consciousness, disorientation, fear, illusions, delusions, hallucinations of any kind, notably visual and tactile, and restlessness, tremor and sometimes fever.

alcohol withdrawal hallucinosis – A psychosis usually of less than six months' duration, with slight or no clouding of consciousness and much anxious restlessness in which auditory hallucinations, mostly of voices uttering insults and threats, predominate.

alcohol withdrawal syndrome – Tremor of hands, tongue, and eyelids following cessation of prolonged heavy drinking of alcohol. Nausea and vomiting, dry mouth, headache, heavy perspiration, fitful sleep, acute anxiety attacks, mood depression, feelings of guilt and remorse, and irritability are associated features.

Correct Coding Initiative

❖ Indicates a mutually exclusive edit

0001F No CCI edits apply for this code.

0001T 0002T❖, 34800❖-34804❖, 36000, 36410, 90780

0002F No CCI edits apply for this code.

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90802	90862, 90901, 96115, 96150-96155, 97802-97804, 99201-99285, 99291❖-99292❖, 99295-99296, 99301-99313, 99321-99357, 99360,

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