

## Section 4 – Claim Submission

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# Claim Submission

A provider has many decisions to make when submitting a claim to a payer, public or private.

- What procedure code do I use?
- Do I need to use a modifier?
- What diagnosis code do I use?
- What format should I use – paper or electronic?

This section will answer those questions and define the current industry standards.

### Key Concepts:

- Understanding codes
  - Procedure codes
    - CPT
    - HCPCS
  - Modifiers
  - Diagnosis codes
    - ICD-9
    - ICD-10
  - Place of Service codes
- Billing Formats
  - Superbill
  - CMS 1500 paper claim
  - 835 electronic format claim
- Submission formats
  - Paper
  - Electronic

## Understanding Codes

Various types of codes are used to define **what** service was rendered (procedure code), **why** it was rendered (diagnosis code), **where** it was rendered (place of service code) and if anything affects reimbursement (modifier). These codes are used at the “bottom” of the professional claim form (**Figure 1**). Each code type will be discussed in detail in this section. Over the years, coding has become key to reimbursement, detecting fraud and reporting statistical information used in programs such as the CMS Provider Quality Reporting System (PQRS). Coded data is also analyzed to determine health patterns for quality improvement programs. Staff responsible for coding are no longer just given a list of codes to use for billing, but must now go through stringent examination processes to become certified.

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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)					22. MEDICAID RESUBMISSION CODE					ORIGINAL REF. NO.											
1. _____					3. _____					23. PRIOR AUTHORIZATION NUMBER											
2. _____					4. _____																
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY	CPT/HCPCS		MODIFIER													
where?										what?											

**Figure 1 - Coding section of CMS 1500**

### Procedure Code System

Procedure codes are used to indicate what service, supply or procedure was rendered to the patient. A single procedure code is reported on a service line, in Box 24, field D of the CMS 1500 form (**Figure 2**).

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																					
1. _____										3. _____											
2. _____										4. _____											
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER											
From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS		MODIFIER											

**Figure 2 - Box 24 D on CMS 1500**

Procedure codes were traditionally referred to as either CPT codes or HCPCS codes. It may be confusing, but the correct terminology for the whole procedure coding system is the “*Healthcare Common Procedure Coding System*” (HCPCS). HIPAA redefined how codes are used so that there is now a single standardized code set.

The HCPCS consists of two levels of codes, with the former Level III having been eliminated.

**Level I** is comprised of CPT® (Current Procedural Terminology), copyrighted by the American Medical Association (AMA).

**Level II**, commonly referred to as “HCPCS” codes, are five (5) digit, alpha-number codes (a letter followed by 4 digits) that define non-physician products, supplies, and procedures not included in CPT.

**Level III** codes, also *local codes*, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions. However, these codes were eliminated as a result of HIPAA. Medicare eliminated them from the HCPCS code set effective December 31, 2003.

When both CPT and HCPCS code descriptions are virtually identical, the CPT code should be used. If they are not (one is generic and the other specific), then the more specific code should be used. An example is CPT 99070 – supplies and materials except spectacles. Because there are many HCPCS codes assigned to specific supplies or materials, you should look for a HCPCS code before using 99070.

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Another example is vaccine administration coding. Both HCPCS and CPT have codes for this service; however the CPT manual specifically excludes Medicare patients under the immunization administration codes and directs the use of HCPCS “G” codes instead (see **Appendix 14** for procedure codes used with immunizations).

Immunization	Cost	Codes
HEPATITIS B	The Medicare deductible & co-payment must be paid.	90740, 90746, or 90747 (vaccine) G0010 (administration)

### Level I – CPT® codes

Current Procedural Terminology (CPT®) is a registered trademark for a set of codes developed and maintained by the AMA’s CPT® Editorial Panel. In order to be active, the codes must be widely accepted, have a proven clinical efficacy and, if regarding a drug or device, that drug/device must be FDA approved (or imminent within the approval cycle – such as new vaccines). A relative value unit is then assigned, and CMS approves the code set and publishes it in the Federal Register as the "Medicare Physician Fee Schedule" (go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-to-MPFS-Booklet-ICN901344.pdf> for full instructions). The codes are effective every January 1<sup>st</sup>, and deletions of codes and modifications or descriptions are also effective at that time. You must purchase this code set from the AMA or other medical coding publishers. They are not available for free. There is a Corrections Errata (see **Appendix 15**) that is published quarterly.

Wisconsin requires their use by statute:

#### Wisconsin Statute

Current procedural terminology code changes.

In this section, "current procedural terminology code" means a number established by the American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

### Category I

The codes are **numeric** codes commonly referred to as the “CPT® codes”. They are used to report standard services.

2013 codes:

Anesthesia	00100 – 01999
Integumentary system	10021 – 19499
Musculoskeletal system	20000 – 29999
Respiratory and Circulatory system	30000 – 39599
Digestive system	40490 – 49999
Genitourinary system	50010 – 59899
Nervous system	60000 – 69990
Radiology	70010 – 79999
Pathology/Laboratory	80047 – 89398
Medicine	90281 – 99607
Evaluation & Management (E&M)	99201 – 99499

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### Vaccine Early Release Program<sup>1</sup>

In recognition of the public health interest in vaccine products, the Panel has agreed that new vaccine product codes should be published prior to FDA approval. These codes are indicated with the ( ~~✓~~ ) symbol and will be tracked by the AMA to monitor FDA approval status. Once the FDA status changes to approval, the ( ~~✓~~ ) symbol will be removed. The new vaccine product code(s) will be available through a bi-annual electronic release in January and July in a given CPT cycle to facilitate immunization reporting. The schedule, through 2016, is listed below (Figure 3).

CPT® Category I Vaccine Codes and Category III Codes				
CPT® Book Cycle	CPT Editorial Panel Meeting	Early Release to AMA website	Implementation (6 months after early release)	Published in CPT® Book
2014	May, 2012	July 1, 2012	Jan 1, 2013	2014
	Oct, 2012	Jan 1, 2013	July 1, 2013	
	Jan, 2013	July 1, 2013	Jan 1, 2014	
2015	May, 2013	July 1, 2013	Jan 1, 2014	2015
	Oct, 2013	Jan 1, 2014	July 1, 2014	
	Feb, 2014	July 1, 2014	Jan 1, 2015	
2016	May, 2014	July 1, 2014	Jan 1, 2015	2016
	Oct, 2014	Jan 1, 2015	July 1, 2015	
	Feb, 2015	July 1, 2015	Jan 1, 2016	

**Figure 3 - AMA Early Release Schedule**

### Category II

Prior to 2004, these **alpha-numeric** codes (4 digits followed by the letter **F**) were known as “local codes,” but are now referred to as “performance measurement” codes and are currently optional. These codes should carry no charge and are just reported for information.

The 2013 codes:

Quality Measures	0001F-0015F
Care according to Prevailing Guidelines	0500F-0584F
Elements of History/Review of Systems	1000F-1505F
Elements of Examination	2000F-2060F
Findings from Diagnostic/Screening Tests	3006F-3763F
Therapies Provided (including Preventive Services)	4000F-4563F
Results Conveyed and Documented	5005F-5250F
Elements related to Patient Safety Processes	6005F-6150F

### Category III

These codes are structured the same way as Category II codes. They are reimbursable (if payer benefit covers the service) codes used to designate newly emerging technologies and to track their usage in the medical community. Because these codes are needed as the technology becomes available, they are updated semi-annually in January and July in an early release program (see Figure 1). Category III codes are temporary codes and will be

<sup>1</sup>AMA - <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page>

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updated to a Category I code only if they meet the Category I requirements as described above. If a Category III code is not upgraded to a Category I code within five years, it may be renewed for another 5 years by action of the CPT Editorial Panel or it will automatically be removed from the CPT book

When a Category III code is assigned, it must be used in place of the unlisted procedure code. The use of a Category III code, unlike the unlisted procedure code, permits data collection to substantiate widespread usage of the specific procedure or service that is in the FDA approval.

The 2013 codes are not sectioned. The code range is 0019T to 0328T.

### ***Level II – HCPCS codes***

Healthcare Common Procedure Coding System (HCPCS) are **alpha-numeric** codes, established by CMS's Alpha-Numerical Editorial Panel, used to report non-physician services. They are updated quarterly and are distributed by CMS. You can download these codes for free from CMS at <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>. These are divided into categories:

Transportation services	A0021 – A0999
Enteral and Parenteral Therapy	B4000 – B9999
Outpatient Prospective Payment System (PPS)	C1300 – C9899
Durable Medical Equipment	E0100 – E9999
Procedures/Professional Services (Temporary)	G0008 – G9156
Alcohol and Drug Abuse Treatment Services	H0001 – H2037
Drug Codes	J0120 – J8499
Temporary Codes (use when a permanent DME code is unavailable)	K0000 – K9999
Orthotic Procedures and Devices	L0000 – L4999
Medical Services	M0000 – M0301
Pathology and Laboratory Services	P0000 – P9999
Temporary Codes (use when permanent supply, drug or biological code is unavailable)	Q0035 – Q9968
Diagnostic Radiology services	R0000 – R5999
Temporary National (non-Medicare) Codes (developed for Blue Cross/Blue Shield – ok for private & Medicaid but not Medicare use)	S0000 – S9999
National State Medicaid Codes	T1000 – T9999
Vision Services	V0000 – V2999

*Appendix 1 – Table of Drugs and Biologicals by name (for ease of look-up)*

HCPCS used to include dental codes (D0001 – D9999), but the American Dental Association, who holds the copyright to dental codes, ordered CMS to remove them.

### **Modifiers**

The procedure codes define a specific service. A modifier is a two digit, alpha-numeric code that is added to the end of a procedure code to clarify a service without changing the procedure code. The modifier is used in the second section of Box 24D (**Figure 4**). Up to 4 modifiers are allowed per procedure code, however most claim processing systems only recognize the first position. If more than four modifiers apply, enter modifier 99 in the first modifier field. In the narrative field (item 19 on the claim form), list all modifiers in the correct ranking order, being sure to identify to which detail line or procedure code the modifiers apply.

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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. _____			3. _____							
2. _____			4. _____							
24. A.		DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.
		From		To		PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS
		MM	DD	YY	MM	DD	YY	SERVICE	CPT/HCPCS	MODIFIER
										POINTER

**Figure 4 - Box 24D on CMS 1500**

The modifier can indicate a change in reimbursement or benefit, denote an anatomical site and prevent the appearance of duplicate billing or unbundling. Each code-set has its own set of modifiers. (see **Appendix 16**)

### **CPT® Modifiers**

There are 38 modifiers for CPT® codes. The most relevant to an LHD would be:

<u>Code</u>	<u>Description</u>
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service.
33	Preventive Services

### **HCPCS Modifiers**

There are 319 modifiers for the HCPCS codes. The most relevant to an LHD might be:

<u>Code</u>	<u>Description</u>
JB	Administered subcutaneously
JW	Drug amount discarded/not administered to any patient
SA	Nurse practitioner rendering service in collaboration with a physician
SL	State supplied vaccine

**Figure 5** is an example of billing using a modifier to indicate the funding of the vaccine used for a patient. In the first case, the SL modifier is telling the payer that the vaccine used for the service was funded by the state, and therefore, you are not expecting, nor are you entitled to, reimbursement. It also explains the \$0 charge. Even though you are not charging for that vaccine, you still need bill for it for the following reasons:

- the administration fee makes sense and doesn't cause follow-up, and
- you and the payer have a record in your database for reporting purposes.

When billing privately purchased vaccine, remove the modifier because you do want reimbursement.

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State Supplied				
	Procedure	Modifier	Units	Charge
Vaccine	90658	SL	1	\$0.00
Admin Fee	90465		1	\$15.00
Private Stock				
	Procedure	Modifier	Units	Charge
Vaccine	90658		1	\$14.68
Admin Fee	90465		1	\$15.00

**Figure 5 - Example of Billing with Modifier**

Many payers will list the current vaccines they cover with procedure codes on their websites, usually under their medical policy section. **Figure 6** is an example from United Healthcare for 2013:

<b>Immunizations</b>	<b>Procedure Code(s):</b> <i>(Underlined codes have coverage limitations listed in right hand column):</i> <b>Administration:</b> 90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009, G0010 <b>Hepatitis A:</b> 90632, 90633, 90634, 90636; <b>Hemophilus influenza b:</b> 90645, 90646, 90647, 90648; <b>HPV:</b> <u>90649</u> , <u>90650</u> ; <b>Influenza virus:</b> 90654, 90655, 90656, 90657, 90658, <u>90660</u> , 90661, <u>90662</u> , 90664, 90666, 90667, 90668, 90672, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039; <b>Pneumococcal conjugate:</b> 90669, 90670, S0195; <b>Rotavirus:</b> 90680, 90681; <b>Dtap / Dtpap-IPV, Dtap-Hib-IPV / DTP / DT / Tetanus / Polio / Tdap/ Measles, Mumps, Rubella / MMR:</b> 90696, 90698, 90700, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90713, 90714, 90715, 90719, 90720, 90721, 90723; <b>Varicella:</b> 90716; <b>Pneumococcal:</b> 90732; <b>Meningococcal:</b> 90733, 90734; <b>Zoster:</b> <u>90736</u> ;	90649 is limited to ages 9-26. 90650 is limited to females ages 9-26. 90660 is limited to ages 2-49. 90662 is limited to ages 65+. 90736 is limited to age 60+.
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**Figure 6 - UnitedHealthCare Vaccine Codes**

### Diagnosis Codes (Dx)

Diagnosis codes<sup>2</sup> identify the disease process, an injury or some other condition that defines why a service is being rendered. When submitting a claim for professional services (CMS 1500), there can be up to four active diagnosis codes listed in Box 21, fields 1-4 (**Figure 7**). In Box 24, field E, the field number of the diagnosis for the service being billed is entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER					
1. _____				3. _____							
2. _____				4. _____							
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To										
MM DD YY	MM DD YY			CPT/HCPCS MODIFIER							
										NPI	

**Figure 7 - Box 21 (1-4) and 24E on CMS 1500**

<sup>2</sup> Diagnosis graphics from free e-book site: [http://www.ebookxp.net/ac848faedf/jur01854\\_ch02\\_049-098.in.html](http://www.ebookxp.net/ac848faedf/jur01854_ch02_049-098.in.html)

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### ICD-9 Coding

Diagnosis codes identify the disease process, an injury or some other condition that defines why a service is being rendered. This code set is called the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM or just ICD-9). This system is maintained by the National Center for Health Statistics (NCHS) and CMS. These codes are used world-wide under the auspices of the World Health Organization (WHO). Its purpose was originally to track mortality (death) and morbidity (disease incidence rates). The 9<sup>th</sup> edition was developed to meet additional statistical needs.

### ICD-9 Official Guidelines

The information referred to as the *Official Guidelines* are made up of three volumes:

**Volume 1/Diseases and Injuries: Tabular List** is a listing of all the diseases, conditions, etc., in alphabetic order (see **Figure 8**). This volume has three sections:

1. Diagnosis codes
2. The supplementary classification of non-disease factors and external causes of injury and poisoning.
3. Appendices
  - a. Morphology of Neoplasms
  - b. Deleted effective October 2004
  - c. Classification of Drugs by American Hospital Formulary Services List
  - d. Classification of Industrial Accidents According to Agency
  - e. List of Three-Digit Categories

The image shows a sample page from the ICD-9 Volume 1 Tabular List. It is titled "I. INFECTIOUS AND PARASITIC DISEASES (001-139)". Below the title, there is a note: "Note: Categories for 'late effects' of infectious and parasitic diseases are to be found at 137-139." This is followed by an "Includes:" section listing "Diseases generally recognized as communicable or transmissible as well as a few diseases of unknown but possible infectious origin." and an "Excludes:" section listing "acute respiratory infections (406-466)", "carrier or suspected carrier of infectious organism (V02.0-V02.9)", "certain localized infections", and "influenza (487.0-487.8)". Below this is the section "INTESTINAL INFECTIOUS DISEASES (001-009)" with its own "Excludes:" section listing "helminthiasis (120.0-129)". The main list of codes begins with "001 CHOLERA", which is further broken down into "001.0 DUE TO VIBRIO CHOLERAE", "001.1 DUE TO VIBRIO CHOLERAE EL TOR", and "001.9 CHOLERA, UNSPECIFIED". This is followed by "002 TYPHOID AND PARATYPHOID FEVERS", which includes "002.0 TYPHOID FEVER" (with a sub-note "Typhoid (fever) (infection) [any site]"), "002.1 PARATYPHOID FEVER A", "002.2 PARATYPHOID FEVER B", "002.3 PARATYPHOID FEVER C", and "002.9 PARATYPHOID FEVER, UNSPECIFIED".

Figure 8 - ICD-9 Volume 1 Sample Page

**Volume 2/Diseases and Injuries: Alphabetic Index** is a listing of all codes by their code (see **Figure 9**). This volume is in three sections:

1. Alphabetic Index to Diseases and Injuries
2. Table of Drugs and Chemicals
3. Alphabetic Index to External Causes of Disease and Injuries

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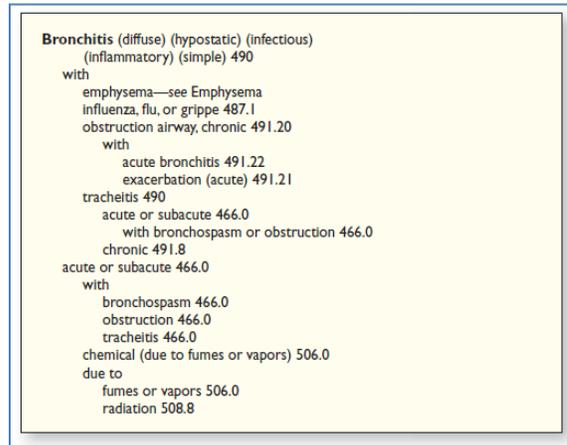


Figure 9 - ICD-9 Volume 2 Sample Page

**Volume 3/Procedures: Tabular List and Alphabetic Index** is a compilation of procedure codes used for inpatient hospital billing only.

These are usually purchased as either Volumes 1 & 2, or all three volumes – the latter needed only for hospital inpatient coding. Hard copy volumes usually contain the lists in backwards order, Volume 2 coming before Volume 1. This supports the process of coding discussed next.

### **ICD-9 Code Structure**

The main ICD-9 codes are either three (3), four (4) or five (5) numeric digits, ranging from 001 (cholera) to 999.9 (other and unspecified complications of medical care, not elsewhere classified).

The three digit code is the base code.

Base code

- represented by three digits from 001 to 999
- may be used as the Dx code if no other factors apply.

4<sup>th</sup> Digit

- represented by using a decimal point and adding the 4<sup>th</sup> digit, as in 376.0
- indicated in manual by a notation or box such as 4<sup>th</sup>
- if present, must be used

5<sup>th</sup> Digit

- represented by the addition of a decimal and 4<sup>th</sup> and 5<sup>th</sup> digits, as in 376.11
- indicated in manual by a notation or box such as 5<sup>th</sup>
- if present, must be used

Any of these levels may have other notations or punctuation that further indicate action. These notes are often displayed with a graphic in order to stand out. For example:

**Include** or  **Exclude** followed by a message or code. Examples in **V** and **E** codes below.

**TIP** or  **CPT Asst** – these can be an instructional note or further specification of what is included in the code. Examples are V403.89 and E001.1 below. The  **CPT Asst** will only give a volume number and publication date. You have to have a CPT Assistant subscription in order to see the actual information, as this too is copyrighted by the AMA.

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Many publications have other graphics for age, new codes, deleted codes, revised codes, etc.

There are two variations on the format where the base code begins with either a **V** or an **E**.

**V codes** are *supplementary classification factors influencing health status and contact with health services*. These range from V01 (contact with or exposure to communicable disease) to V91.99 (other specified multiple gestation, unable to determine the number of placentas and number of amniotic sacs) and are used to indicate a patient who:

- is not currently sick (e.g. preventive care)
- has a known disease but the encounter is for specific treatment (e.g. chemotherapy), or
- has a problem that influences health status (e.g., population status such as *puberty* - V21.1).

An example of the structure is similar to the numeric codes:

**V03** – need for prophylactic vaccination and inoculation against bacterial disease

**Excludes:** *vaccination not carried out (V64.00-V64.09)*  
*vaccines against combinations of diseases (V06.0 – V06.9)*

**V03.8** – other specified vaccinations against single bacterial diseases

**V03.89** – other specified vaccination

**Tip:** *assign for vaccination against Lyme disease*

**E codes** are *supplementary classification of external causes of injury and poisoning*. These range from E000 (external cause status) to E999 (late effect of injury due to war operations and terrorism).

E codes are only classified to the 4<sup>th</sup> digit, so there is never a 5<sup>th</sup> digit. An example is:

**E001** – activities involving walking and running

**Excludes:** *walking an animal (E019.0)*  
*Walking or running on a treadmill (E0090)*

**E001.1** – walking, marching, hiking

*Walking, marching, hiking on a level terrain*

**Excludes:** *mountain climbing (E004.0)*

Dx codes for vaccination services are mostly in the V01-V06 (*Persons with Potential Health Hazards Related to Communicable Diseases*).

### ICD-10 Coding

Effective October 1, 2014, ICD-9 will be replaced with the ICD-10 coding system, as mandated by HIPAA 1996. A number of other countries have already moved to ICD-10, including:

United Kingdom (1995);  
France (1997);  
Australia (1998);  
Germany (2000); and  
Canada (2001).

The reasons for the change are many and will not be discussed here. Suffice to say, the new code structure brings more intelligence to a code, creating almost 20% more codes. Elements that used to be designated with modifiers, such as RT (right) or LT (left) are now built into the code. American spelling of medical terms is being used. Documentation will also be affected:

- Codes must be supported by medical documentation

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- ICD-10-CM codes are more specific
- Requires more documentation to support codes
- Expect a 15% increase in documentation time (per AAPC).

The main differences, besides structure, are:

**ICD-9**

14,019 available codes  
 Limited space for new codes  
 Lacks detail

**ICD-10**

68,103 available codes<sup>3</sup>  
 Flexible for adding new codes  
 Very specific

As with ICD-9, there are two code sets<sup>4</sup>:

**ICD-10-CM** is for use in all U.S. health care settings.

**ICD-10-PCS** is for use in U.S. inpatient hospital settings only. There are 3,824 ICD-9 codes compared to 72,589 ICD-10 codes. **Note:** This will not be discussed in this document since it is not relevant to LHD coding.

### *ICD-10 Official Guidelines*

ICD-10 doesn't change the essence of *Official Guidelines*. The basic structure is retained as demonstrated in **Figure 10**.

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**Figure 10 - ICD-10 Manual Contents Page**

**Volume 1/Diseases and Injuries: Tabular List** is structured similarly to ICD-9-CM (**Figure 11**), with minor exceptions:

<sup>3</sup> [http://www.multiplan.com/ICD10\\_HIPAA5010/pdf/ICD-10\\_InfoBulletin\\_Clients\\_January%202013.pdf](http://www.multiplan.com/ICD10_HIPAA5010/pdf/ICD-10_InfoBulletin_Clients_January%202013.pdf)

<sup>4</sup> ICD-10 information from CMS website

## Section 4 – Claim Submission

- A few chapters have been restructured
- Sense organs (eye and ear) are separated from Nervous System chapter and moved to their own chapters

ICD-10-CM Index to Diseases and Injuries		
<p><b>A</b></p> <p><b>Aarskog's syndrome</b> Q87.1</p> <p><b>Abandonment</b> — see Maltreatment, abandonment</p> <p><b>Abasia</b> (-astasia) (hysterical) F44.4</p> <p><b>Abderhalden-Kaufmann-Lignac syndrome</b> (cystinosis) E72.04</p> <p><b>Abdomen, abdominal</b> — see also condition</p> <p>acute R10.0</p> <p>angina K55.1</p> <p>muscle deficiency syndrome Q79.4</p> <p><b>Abdominalgia</b> — see Pain, abdominal</p> <p><b>Abduction contracture, hip or other joint</b> — see Contracture, joint</p> <p><b>Aberrant</b> (congenital) — see also Malposition, congenital</p> <p>adrenal gland Q89.1</p> <p>artery (peripheral) Q27.8</p> <p>basilar NEC Q28.1</p> <p>cerebral Q28.3</p> <p>coronary Q24.5</p> <p>digestive system Q27.8</p> <p>eye Q15.8</p> <p>lower limb Q27.8</p> <p>precerebral Q28.1</p> <p>pulmonary Q25.7</p> <p>renal Q27.2</p> <p>retina Q14.1</p> <p>specified site NEC Q27.8</p> <p>subclavian Q27.8</p> <p>upper limb Q27.8</p> <p>vertebral Q28.1</p> <p>breast Q83.8</p> <p>endocrine gland NEC Q89.2</p> <p>hepatic duct Q44.5</p> <p>pancreas Q45.3</p>	<p><b>Abnormal, abnormality, abnormalities— continued</b></p> <p>blood level (of)</p> <p>cobalt R79.0</p> <p>copper R79.0</p> <p>iron R79.0</p> <p>lithium R78.89</p> <p>magnesium R79.0</p> <p>mineral NEC R79.0</p> <p>zinc R79.0</p> <p>blood pressure</p> <p>elevated R83.0</p> <p>low reading (nonspecific) R83.1</p> <p>blood sugar R73.89</p> <p>bowel sounds R19.15</p> <p>absent R19.11</p> <p>hyperactive R19.12</p> <p>brain scan R94.02</p> <p>breathing R86.9</p> <p>caloric test R94.138</p> <p>cerebrospinal fluid R83.9</p> <p>cytology R83.6</p> <p>drug level R83.2</p> <p>enzyme level R83.0</p> <p>hormones R83.1</p> <p>immunology R83.4</p> <p>microbiology R83.5</p> <p>nonmedicinal level R83.3</p> <p>specified type NEC R83.8</p> <p>chemistry, blood R79.9</p> <p>C-reactive protein R79.82</p> <p>drugs — see Findings, abnormal, in blood</p> <p>gas level R79.81</p> <p>minerals R79.0</p> <p>pancytopenia R79.1</p> <p>specified NEC R79.89</p> <p>PTT R79.1</p> <p>toxins — see Findings, abnormal, in blood</p>	<p><b>Abnormal, abnormality, abnormalities— continued</b></p> <p>cytology</p> <p>anus R85.619</p> <p>atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H) R85.611</p> <p>atypical squamous cells of undetermined significance (ASC-US) R85.610</p> <p>cytologic evidence of malignancy R85.614</p> <p>high grade squamous intraepithelial lesion (HSIL) R85.613</p> <p>human papillomavirus (HPV) DNA test</p> <p>high risk positive R85.81</p> <p>low risk positive R85.82</p> <p>inadequate smear R85.615</p> <p>low grade squamous intraepithelial lesion (LSIL) R85.612</p> <p>satisfactory cervical smear but lacking transformation zone R85.616</p> <p>specified NEC R85.618</p> <p>unsatisfactory smear R85.615</p> <p>female genital organs — see Abnormal, Papanicolaou (smear)</p> <p>dark adaptation curve H53.61</p> <p>dentofacial NEC — see Anomaly, dentofacial development, developmental Q89.9</p> <p>central nervous system Q07.9</p> <p>diagnostic imaging</p> <p>abdomen, abdominal region NEC R93.5</p> <p>biliary tract R93.2</p> <p>breast R92.8</p> <p>central nervous system NEC R90.89</p> <p>cerebrovascular NEC R90.89</p> <p>coronary circulation R93.1</p> <p>digestive tract NEC R93.3</p> <p>gastrointestinal (tract) R93.3</p> <p>genitourinary organs R93.8</p>

Figure 11 - ICD-10 Volume 1 Sample Page

**Volume 2/Diseases and Injuries: Alphabetic Index** – as seen in **Figure 12**, this volume remains the same as ICD-10.

1. Alphabetic Index of Diseases and Injuries
2. Alphabetic Index of External Causes
3. Table of Neoplasms
4. Table of Drugs and Chemicals

# Section 4 – Claim Submission

S00-500.272	Injury, Poisoning and Certain Other Consequences of External Causes	ICD-10-CM Draft (2013)
<p><b>Chapter 19. Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)</b></p> <p><b>NOTE</b> Use secondary code(s) from Chapter 20, External causes of morbidity, to indicate cause of injury. Codes within the T section that include the external cause do not require an additional external cause code.</p> <p>Use additional code to identify any retained foreign body, if applicable (Z18.-)</p> <p><b>EXCLUDES1</b> birth trauma (P10-P15) obstetric trauma (O70-O71)</p> <p>This chapter contains the following blocks:</p> <p>S00-S09 Injuries to the head S10-S19 Injuries to the neck S20-S29 Injuries to the thorax S30-S39 Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals S40-S49 Injuries to the shoulder and upper arm S50-S59 Injuries to the elbow and forearm S60-S69 Injuries to the wrist, hand and fingers S70-S79 Injuries to the hip and thigh S80-S89 Injuries to the knee and lower leg S90-S99 Injuries to the ankle and foot T07 Injuries involving multiple body regions T14 Injury of unspecified body region T15-T19 Effects of foreign body entering through natural orifice T20-T25 Burns and corrosions of external body surface, specified by site T26-T28 Burns and corrosions confined to eye and internal organs T30-T32 Burns and corrosions of multiple and unspecified body regions T33-T34 Frostbite T36-T50 Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances T51-T65 Toxic effects of substances chiefly nonmedicinal as to source T66-T78 Other and unspecified effects of external causes T79 Certain early complications of trauma T80-T88 Complications of surgical and medical care, not elsewhere classified</p> <p>The chapter uses the S-section for coding different types of injuries related to single body regions and the T-section to cover injuries to unspecified body regions as well as poisoning and certain other consequences of external causes.</p> <p><b>Injuries to the head (S00-S09)</b></p> <p><b>INCLUDES</b> injuries of ear injuries of eye injuries of face [any part] injuries of gum injuries of jaw injuries of oral cavity injuries of palate injuries of scalp</p>		
S00-500.272		<p><b>S00.0</b> Superficial injury of scalp</p> <p><b>S00.00</b> Unspecified superficial injury of scalp</p> <p><b>S00.01</b> Abrasion of scalp</p> <p><b>S00.02</b> Blister (nonthermal) of scalp</p> <p><b>S00.03</b> Contusion of scalp</p> <p><b>S00.04</b> External constriction of part of scalp</p> <p><b>S00.05</b> Superficial foreign body of scalp</p> <p><b>S00.06</b> Insect bite (nonvenomous) of scalp</p> <p><b>S00.07</b> Other superficial bite of scalp</p> <p><b>S00.1</b> Contusion of eyelid and periorcular area</p> <p><b>S00.10</b> Contusion of unspecified eyelid and periorcular area</p> <p><b>S00.11</b> Contusion of right eyelid and periorcular area</p> <p><b>S00.12</b> Contusion of left eyelid and periorcular area</p> <p><b>S00.2</b> Other and unspecified superficial injuries of eyelid and periorcular area</p> <p><b>S00.20</b> Unspecified superficial injury of eyelid and periorcular area</p> <p><b>S00.201</b> Unspecified superficial injury of right eyelid and periorcular area</p> <p><b>S00.202</b> Unspecified superficial injury of left eyelid and periorcular area</p> <p><b>S00.209</b> Unspecified superficial injury of unspecified eyelid and periorcular area</p> <p><b>S00.21</b> Abrasion of eyelid and periorcular area</p> <p><b>S00.211</b> Abrasion of right eyelid and periorcular area</p> <p><b>S00.212</b> Abrasion of left eyelid and periorcular area</p> <p><b>S00.219</b> Abrasion of unspecified eyelid and periorcular area</p> <p><b>S00.22</b> Blister (nonthermal) of eyelid and periorcular area</p> <p><b>S00.221</b> Blister (nonthermal) of right eyelid and periorcular area</p> <p><b>S00.222</b> Blister (nonthermal) of left eyelid and periorcular area</p> <p><b>S00.229</b> Blister (nonthermal) of unspecified eyelid and periorcular area</p> <p><b>S00.24</b> External constriction of eyelid and periorcular area</p> <p><b>S00.241</b> External constriction of right eyelid and periorcular area</p>

Figure 12 - ICD-10 Volume 2 Sample Page

**Volume 3/Procedures: Tabular List and Alphabetic Index** – this is also unchanged and will not be discussed here as it is for inpatient hospital billing only.

### ICD-10 Code Structure

The coding structure (**Figure 13**) is the biggest change in coding. These codes provide greater specificity to identify disease etiology, anatomic site, and severity. Like the ICD-9, there are three levels<sup>5</sup>:

- Characters 1-3                      Category
- Characters 4-6                    Etiology, anatomic site, severity, clinical detail
- Characters 7                        Extension

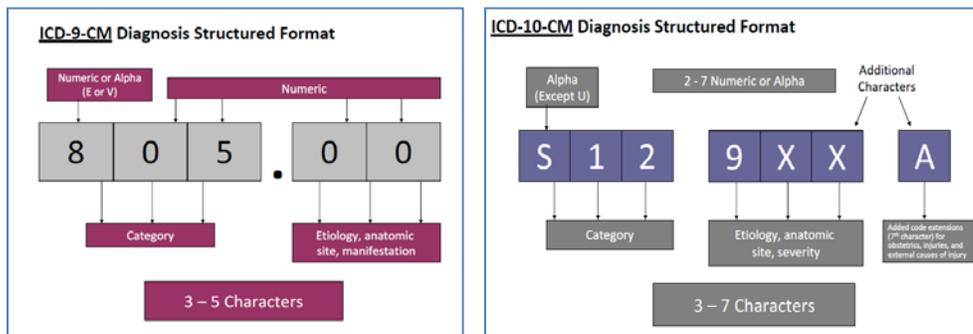


Figure 13 - Code Structure Comparison

Differences between the code structures

<sup>5</sup> <http://www.ncvhs.hhs.gov/091210p06b.pdf>

## Section 4 – Claim Submission

ICD-9	ICD-10
3 – 5 characters	5 – 7 characters
1 <sup>st</sup> character is numeric (except for V & E codes)	1 <sup>st</sup> character is alpha All letters used except for “U”
2 <sup>nd</sup> – 5 <sup>th</sup> characters are numeric (except for F or T in 5 <sup>th</sup> for limited codes)	2 <sup>nd</sup> – 7 <sup>th</sup> characters are alpha or numeric
Use of 0 as placeholder	“X” used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character
	Alpha characters not case sensitive

Similar to HCPCS Level II codes, ICD-10 codes begin with an alpha character that defines the chapter:

<b>ICD-10 1<sup>st</sup> character</b>	<b><u>Classification</u></b>
<b>A-B</b>	Infectious/Parasitic Diseases
<b>C</b>	Neoplasms
<b>D</b>	Diseases of Blood/Blood-Forming Organs
<b>E</b>	Endocrine, Nutritional, and Metabolic Diseases
<b>F</b>	Mental and Behavioral Disorders
<b>G</b>	Diseases of the Nervous System
<b>H</b>	Diseases of the Eye, Adnexa, Ear and Mastoid Process
<b>I</b>	Diseases of the Circulatory System
<b>J</b>	Diseases of the Respiratory System
<b>K</b>	Diseases of the Digestive System
<b>L</b>	Diseases of Skin and Subcutaneous Tissue
<b>M</b>	Diseases of Musculoskeletal System
<b>N</b>	Diseases of the Genitourinary System
<b>O</b>	Pregnancy, Childbirth, and the Puerperium
<b>P</b>	Certain conditions originating in perinatal
<b>Q</b>	Congenital malformations, deformations, and chromosomal abnormalities
<b>R</b>	Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified
<b>S-T</b>	Injury, poisoning, certain other consequences of external causes
<b>U</b>	no codes listed - will be used for emergency code additions
<b>V-Y</b>	External causes of morbidity
<b>Z</b>	Factor influencing health status

The following example shows the more detailed information gained through the added characters. You can see the specificity of ICD-10 noted in *italics*.

### ICD-9

**813.45** *Torus fracture of radius (alone)*

**Excludes torus fracture of radius and ulna (813.47)**

## Section 4 – Claim Submission

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**NOTE:** 813 alone is the fracture of radius, lower end, closed

### ICD-10

#### S52 Fracture of forearm

<p>The appropriate 7th character is to be added to all codes from category S52 [unless otherwise indicated].</p> <ul style="list-style-type: none"> <li>A Initial encounter for closed fracture</li> <li>B Initial encounter for open fracture type I or II</li> <li>C Initial encounter for open fracture type IIIA, IIIB, or IIIC</li> <li>D Subsequent encounter for closed fracture with routine healing</li> <li>E Subsequent encounter for open fracture type I or II with routine healing</li> <li>F Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing</li> <li>G Subsequent encounter for closed fracture with delayed healing</li> <li>H Subsequent encounter for open fracture type I or II with delayed healing</li> <li>J Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing</li> <li>K Subsequent encounter for closed fracture with nonunion</li> <li>M Subsequent encounter for open fracture type I or II with nonunion</li> <li>N Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion</li> <li>P Subsequent encounter for closed fracture with malunion</li> <li>Q Subsequent encounter for open fracture type I or II with malunion</li> <li>R Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion</li> <li>S Sequela</li> </ul>
---

#### S52.5 Fracture of lower end of radius

##### S52.52 Torus fracture of lower end of radius

##### S52.521 Torus fracture of lower end of right radius

##### S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture

### Dummy Placeholder

Next is an example of using the X placeholder. The diagnosis in the medical record is *glaucoma secondary to drugs, right eye, and severe stage*. Note below that the entry for the base code requires a 5<sup>th</sup> digit. Additionally, there is a box indicating options for the required 7<sup>th</sup> digit. But there is no code available with a 6<sup>th</sup> digit. The code H40.61 is the most appropriate and the use of a 7<sup>th</sup> digit of “3” is needed to indicate the stage. Since there is no 6<sup>th</sup> digit available in the coding structure, an X is placed as a dummy placeholder before the 7<sup>th</sup> digit. This same logic applies to any missing 5<sup>th</sup> or 6<sup>th</sup> digit as well and is required when applicable.

Code will be: **H40.61X3**

#### 5<sup>th</sup> H40.6 Glaucoma secondary to drugs

<p>The appropriate 7th character is to be assigned to each code in subcategory H40.6, to designate the stage of glaucoma:</p> <ul style="list-style-type: none"> <li>0 stage unspecified</li> <li>1 mild stage</li> <li>2 moderate stage</li> <li>3 severe stage</li> <li>4 interminate stage</li> </ul>
--

<input checked="" type="checkbox"/> x 7 <sup>th</sup>	H40.60	Glaucoma secondary to drugs, unspecified eye
<input checked="" type="checkbox"/> x 7 <sup>th</sup>	H40.61	Glaucoma secondary to drugs, right eye
<input checked="" type="checkbox"/> x 7 <sup>th</sup>	H40.62	Glaucoma secondary to drugs, left eye
<input checked="" type="checkbox"/> x 7 <sup>th</sup>	H40.63	Glaucoma secondary to drugs, bilateral

### Immunization Code

## Section 4 – Claim Submission

The new code is great for LHD's – there is a single code for use with vaccination services!

**Z23** Encounter for immunization  
Code first any routine childhood examination  
**NOTE** Procedure codes are required to identify the types of immunizations given

The following ICD-10-CM Index entries contain back-references to vaccinations:

Admission (for) - see also Encounter (for)

Prophylactic (measure)

vaccination **Z23**

Immunization - see also Vaccination

encounter for **Z23**

Prophylactic

vaccination **Z23**

Vaccination (prophylactic)

encounter for **Z23**

### Stay Up-to-date on Codes

The following webpage (**Figure 14**) contains updates on ICD-9, ICD-10 and HCPCS code sets. You can sign-up for automatic an email notice when a change is posted. Go to <http://www.codingupdates.com/>



Figure 14 - Code Updates Website

### Place of Service Codes

Place of Service (POS) codes (**Appendix 17**) are used to indicate where the service was rendered (**Figure 15**). They are only used on professional claims. POS codes most likely used by a LHD are:

Code	Description
18	Place of Employment – Worksite
60	Mass Immunization Center
70	Public Health Clinic

## Section 4 – Claim Submission

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. _____			3. _____							
2. _____			4. _____							
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER
From			To			SERVICE	EMG	CPT/HCPCS		MODIFIER
MM	DD	YY	MM	DD	YY					

Figure 15 - Box 24B on CMS 1500

For a summary of **all** codes relative to immunization services – see **Appendix 18**.

## Billing

### Formats

There are three formats used in provider billing:

- Superbill
- CMS 1500 paper claim
- 837 electronic format claim

The Superbill has traditionally been used by smaller provider practices. It is no longer recommended; though some payers will accept it.

### *Superbill*

The Superbill was created to allow practitioners to quickly and efficiently create a billing record for each patient. There is no standard format. These documents are usually created based on the most common services provided in that specific practice. **Appendix 19** is a sample of a common Superbill<sup>6</sup>. This example is a **two sided** document with patient information and services (procedure codes) on the front and the diagnosis codes (ICD-9) on the back. The provider just checks the appropriate box(s), and their office can then complete the billing portion at the top of the form and submit to a payer.

It should be noted that the same template has expanded from the billing/services page with a single diagnosis page to a billing/services page plus eight pages of ICD-10 codes.

**Figure 16** demonstrates the options a Superbill for a family practice might have for immunization services, including the vaccine and administration codes:

<sup>6</sup> AAPC sample of an AAFP Superbill template

## Section 4 – Claim Submission

Vaccines	
DT, <7 y	90702
DTP	90701
DtaP, <7 y	90700
Flu, 6-35 months	90657
Flu, 3 y +	90658
Hep A, adult	90632
Hep A, ped/adol, 2 dose	90633
Hep B, adult	90746
Hep B, ped/adol 3 dose	90744
Hep B-Hib	90748
Hib, 4 dose	90645
HPV	90649
IPV	90713
MMR	90707
Pneumonia, >2 y	90732
Pneumonia conjugate, <5 y	90669
Td, >7 y	90718
Varicella	90716
Immunizations & Injections	
	Units
Allergen, one	95115
Allergen, multiple	95117
Imm admin, one	90471
Imm admin, each add'l	90472
Imm admin, intranasal, one	90473
Imm admin, intranasal, each add'l	90474
Injection, joint, small	20600
Injection, joint, intermediate	20605
Injection, joint, major	20610
Injection, ther/proph/diag	90772
Injection, trigger point	20552

**Figure 16 - Superbill vaccine options**

### ***CMS 1500 (8/05) Paper Claim Form***

The CMS 1500 (v 8/05) claim form (**Appendix 20**) is the industry standard for professional services, as opposed to facility billers where the UB-04 is used. It is designed and maintained by the *National Uniform Claim Committee*.<sup>7</sup> The forms must be printed in *Flint OCR Red, J6983* (or exact match) ink. The majority of payers will scan the form on arrival at the claims processing location, so the forms need to be Optical Character Recognition (OCR) ready. Provider can obtain their supply by contacting the U.S. Government Printing Office at 1-866-512-1800 or any of many online vendors.

These forms are required by statute in Wisconsin. WI Statute 632.75 ordered the OCI to require standardized health insurance claim forms, and in 1993, the OCI Administrative Code Ins. 3.65 did just that.

The Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies not submitted to Medicare electronically, with limited exceptions. LHD's meeting one or more of the situations below would be able to submit the CMS 1500.

- Small provider -- Medicare considers all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and who are required to bill a Medicare Part B contractor to be small providers;
- Roster billing of inoculations or immunizations covered by Medicare;
- Medicare secondary payer (MSP) claims when there is *more than* one primary payer, and one or more of those payers made an "**Obligated to accept as payment in full**" adjustment;

<sup>7</sup> [http://www.nucc.org/images/stories/PDF/version\\_0212\\_cms\\_1500.pdf](http://www.nucc.org/images/stories/PDF/version_0212_cms_1500.pdf)

## Section 4 – Claim Submission

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- Disruption in electricity or communication connections outside of a provider's control expected to last more than two business days (e.g., providers affected by Hurricane Katrina);
- Claims from providers who submit fewer than 10 claims *per month* on average during a calendar year.

Providers self-assess to determine if they meet one or more of these situations and do not need to submit a waiver request when they meet one or more of these situations.

Completing the form is fairly straight forward once all your information has been gathered. There are numerous instructions on the Web in completing the CMS 1500 for submission, including the following:

- **CMS:** <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1393CP.pdf>
- **CMS:** [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/form\\_cms-1500\\_fact\\_sheet.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf)
- **Forward Health:** <https://www.forwardhealth.wi.gov/kw/pdf/2006-95.pdf>
- **NUCC:** [http://www.nucc.org/images/stories/PDF/claim\\_form\\_manual\\_v8-0\\_7-12.pdf](http://www.nucc.org/images/stories/PDF/claim_form_manual_v8-0_7-12.pdf)

### ***ASC X12N 837: Professional Claim***

HIPAA 1996 mandated HHS to adopt standards for all administrative and financial health care transactions between covered entities, which essentially includes all health plans, providers as well as Medicare and Medicaid. A crosswalk (**Appendix 21**) is used to compare the CMS 1500 fields to the 837P.

The HIPAA standards adopted the format defined by the Accredited Standards Committee (ASC) X12. A subcommittee for insurance defined the X12N standards related to health care. Very complex and detailed (768 pages in the 837 guide) documents called “implementation guides” are used to define every field and character of an electronic file. There is a separate guide for each of the formats (**Figure 17** below) that transfer health care data electronically. Additionally, there are multiple versions of the X12, with the current version being 005010.

Transaction	Description
270	Health Plan Eligibility Inquiry
271	Health Plan Eligibility Response
276	Claim Status Request
277	Claim Status Response
278(Q/R)	Referral Request and Response
820	Health Plan Premium Payment
834	Health Plan Enrollment
835	Health Care Claim Payment
837(I)	Health Care Claim and COB: Institutional
837(D)	Health Care Claim and COB: Dental
<b>837(P)</b>	<b>Health Care Claim and COB: Professional</b>
275	Additional Information to support a health care claim or Encounter
277	Claim Request for Additional Information

## Section 4 – Claim Submission

997	Functional Acknowledgement for Health Care Insurance
999	Implementation Acknowledgement
277CA	Health Care Claim Acknowledgement

**Figure 17 - HIPAA Transactions**

When referring to the relationship between entities that trade electronic data, such as an LHD and a payer, the term is “trading partner.” While the implementation guides lay out required elements, there is allowance for situational scenarios, so each trading partner has a “companion guide” to supplement implementation guide with all the situational items defined for their particular needs. **Figure 18** demonstrates that a procedure code is required, along with the type of code being used (HC=HCPCS), but the modifier (★) is situational and only used if applicable.

Loop 2430 – Line Adjudication Information			
Usage	Segment	Value	Comment
Required	SVD01		Payer Identification Code
Required	SVD02		The amount paid by the primary payer for each service line. Zero (0) is an acceptable value for this element.
Required	SVD03-1	HC = Healthcare Common Procedure Coding System (HCPCS) Codes IV = Home Infusion EDI Coalition (HIEC) Product/Service Code ZZ = Mutually Defined	Code to identify the type of medical procedure.
Required	SVD03-2		Procedure Code
Situational	SVD03-3		Procedure Code Modifier Procedure Modifier 1 ★
Situational	SVD03-4		Procedure Code Modifier Procedure Modifier 2 ★

**Figure 18 - Required vs Situational Data**

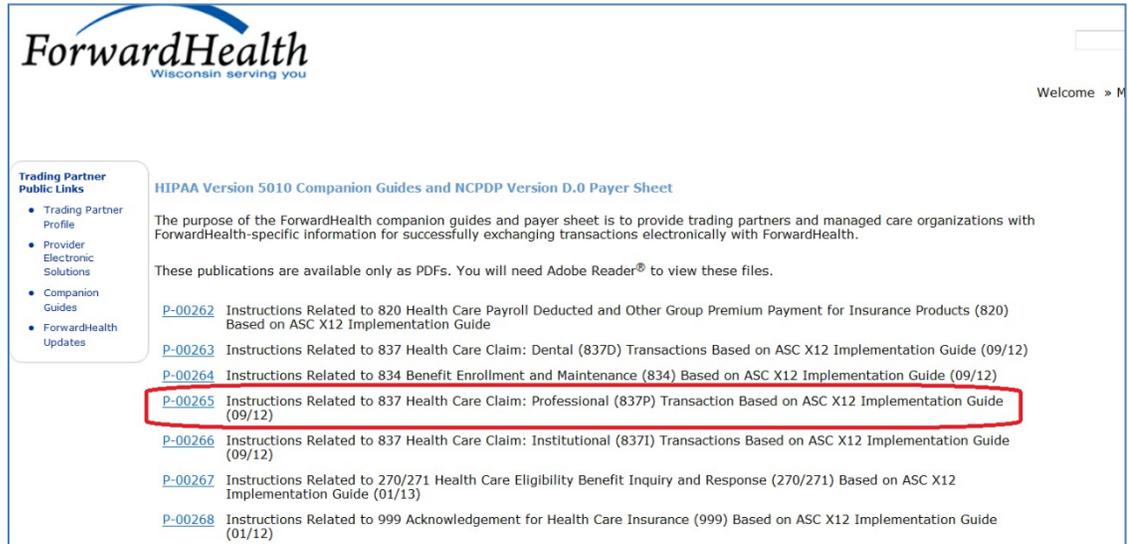
Most trading partners post their “companion guides” on their websites. **Figures 19 and 20** show where to go for Medicaid guides from Forward Health’s homepage.

The screenshot shows the ForwardHealth Wisconsin portal. The main navigation includes:
 

- Providers:** Register for E-mail Subscription, Provider-specific Resources, Become a Provider, Online Handbooks, Fee Schedules, Trainings, Wisconsin Administrative Code, ForwardHealth Enrollment Data, Health Care Enrollment, Provider Revalidation, Enrollment Tracking Search, Bed Assessment e-Payment, Primary Care Rate Attestation **NEW**.
- Managed Care:** Related Programs and Services.
- Hot Topics:** **NEW** Medical Transportation Management, Inc. Will Begin Providing NEMT Services on August 1, 2013; Enhanced Ambulatory Patient Groups (EAPG).
- Members:** Member Information, Find a Provider, Member Contacts.
- Partners:** Find a Provider, Related Programs and Services.
- Trading Partners:** Trading Partner Profile, Companion Guides (highlighted with a red box).

**Figure 19 - Forward Health Companion Guide link**

## Section 4 – Claim Submission



**Figure 20 - Forward Health 837 Professional Claim Companion Guide**

Because there are so many “companion guides” and it would be impossible for providers to keep up with every change, clearinghouses are often employed as a middleman in the transfer of data. Clearinghouses may receive non-standard transactions from a provider, but they must convert these into standard transactions for submission to the health plan. Similarly, if a health plan contracts with a clearinghouse, the health plan may submit non-standard transactions to the clearinghouse, but the clearinghouse must convert these into standard transactions for submission to the provider.

A "direct data entry" process, where the data is directly keyed by a health care provider into a health plan’s computer using dumb\* terminals or computer browser screens, would not have to use the format portion of the standard, but the data content must conform.

\* A dumb terminal consists of a monitor and keyboard that allows for data input and screen output and no data processing capability. It is connected to another, intelligent computer or system for actual processing. Dumb terminals are used by airlines, banks, and other such firms for inputting data to, and recalling it from, the connected computer.

## Submission

### Paper

Paper claims should be sent to the address indicated on the member’s ID card. Addresses vary according to whether or not the payer has a third-party vendor that will transfer the claims from paper to electronic formats using OCR, if there is a clearinghouse involved, or if there is a re-pricing entity (e.g. PPO) involved. These variations are at the group level, so looking at the ID card is imperative.

### *Immunization Specific Tips*

#### **Medicaid**

Forward Health has a detailed description of how to fill out the CMS 1500 claim form in the online manual by selecting (**Figure 21**):

*Provider/HealthCheck/Claims/Submission/1500 Health Insurance Claim Form Completion Instructions for HealthCheck Services.*

## Section 4 – Claim Submission

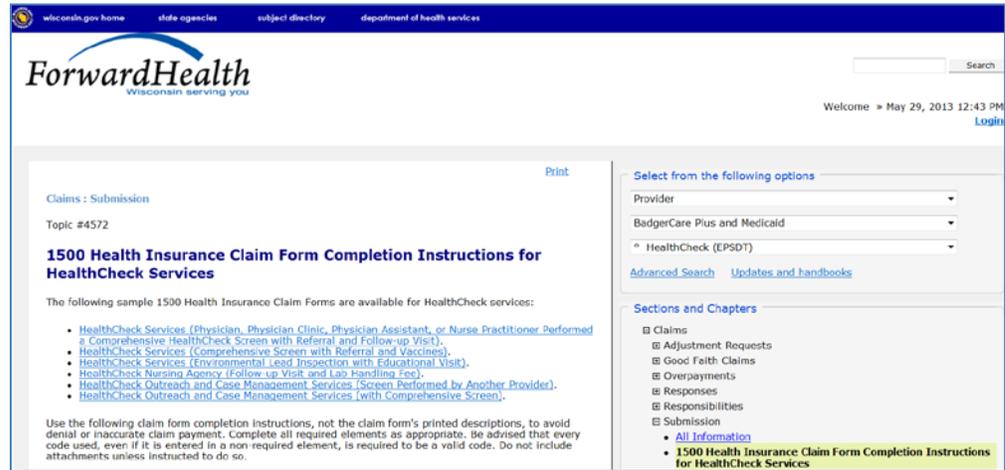


Figure 21 - Forward Health Claim Submission Instructions

Topic #517 (Usual and Customary Charges) clearly states:

*Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.*

This means that an LHD cannot provide “free” services to an uninsured person, if they are charging Medicaid (or Medicare) a greater amount. The charge must be the same to all and if the person cannot pay, work within their hardship policy to resolve the issue.

Topic #4572 (1500 Health Insurance Claim Form Completion Instructions for HealthCheck Services)

Some immunizations, based on patient age, will not be covered under HealthCheck unless they are correctly billed. For instance, there are two Hepatitis A codes (**Figure 22**). Code 90633 is the pediatric/adolescent dose and is found on the Medical Services fee schedule if the rendering provider type is 72 (HealthCheck). However, the adult version, 90632, is only payable if the rendering provider type is 9 (NP), 10 (PA) or 31 (MD). In order to receive reimbursement for both, the correct information must on the CMS 1500.

90632 <sup>1</sup>	Hepatitis A vaccine, adult dosage, for intramuscular use
90633 <sup>1</sup>	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use

Figure 22 - Hepatitis A codes

**Element 24J — Rendering Provider ID #** (see **Figure 23**)

In the case of procedure code **90632**, the NPI used must be one with the rendering provider types, not the LHD.

In the case of procedure code **90633**, since the LHD is a provider type 72, no additional NPI must be entered here.

**Element 33 — Billing Provider Info and Phone Number**

This can be the LHD’s information for both, since a HealthCheck provider is enrolled as a “rendering/billing” provider.

## Section 4 – Claim Submission

### Element 33a — NPI

Enter the NPI of the billing provider or the LHD.

2. I		4. I		E		F.		G.		H.		J.						
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		F. CHARGES		G. DAYS OF WEEK		H. UNIT		J. RENDERING PROVIDER ID #		
From	To	MM	DD	YY	MM	DD	YY	EMG	(Explain Unusual Circumstances)		Modifier	1	2	3	4	5	6	
10	15	11			11				90669			XXX	XX	1				123456789X 0111111110
2	10	15	11		11				90713			XX	XX	1				123456789X 0111111110
3	10	15	11		11				90700			XXX	XX	1				123456789X 0111111110
4	10	15	11		11				90648			XXX	XX	1				123456789X 0111111110
5	10	16	11		11				99391	UA		XXX	XX	1				123456789X 0111111110
6																		

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
			123456	YES <input type="checkbox"/> NO <input type="checkbox"/>	XXX.XX	XXX.XX	XXX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	33. BILLING PROVIDER INFO & PH #
<i>J.M. Provider</i>	I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234
SIGNED DATE 11/30/2011	* 022222220    ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

**Figure 23 - Billing vs Rendering Provider**

### Electronic Claim

Each payer and/or clearinghouse will have their own process to sign up for EDI transactions. **Figures 24 and 25** demonstrate how to sign up directly with a payer like WPS. Each step has a hyperlink to the required forms and requirements for each step. With all trading partners, you will have to sign a “trading partner agreement” and supply test files before you can be operational with them. You will, no doubt, need IT support in this process.

### Getting Started with Electronic Claim Filing in Five Easy Steps

Making the decision to send your healthcare claims electronically puts you only five steps away from all the benefits EDI has to offer. Follow the five easy steps below to get started with EDI for your business. Staff at the WPS EDI department are here to help with the process. [Contact EDI](#).

**Step 1:**  
[Choose your claim filing option](#)

**Step 2:**  
[Choose your submission method](#)

**Step 3:**  
[Register on WTPS](#)

**Step 4:**  
[Complete your EDI agreement form](#)

**Step 5:**  
[Complete testing](#)

**To submit claims electronically you may need:**

- Personal Computer
- Internet access
- EDI software program
- WPS Submitter ID
- Access to a Modem

**Forms**

- [WPS Commercial and EPIC](#)
- [Medicare](#)
- [Tricare](#)

**Figure 24 - WPS EDI Claim Filing Process**

For instance, Step 2 gives you options for submission methods for commercial claims:

## Section 4 – Claim Submission

### Step 2: Choose Your Submission Method

#### Submission Methods

- [WPS Bulletin Board System \(BBS\)](#) asynchronous telecommunications.; This method requires using a modem to dial up and connect to the WPS BBS.
- [WPS Secure-EDI](#)  - **NOT AVAILABLE FOR MEDICARE per CMS regulations.** This method will allow secure FTP file transfer using your internet web browser.

Figure 25 - WPS EDI Submission options

Since you won't find one source with all of the connections you need, you will want to look for a clearinghouse or billing software company that has the majority of payers to whom you submit claims on their "payer list." Most of these vendors have a link listing payers, where you see if your major payers are included. **Appendix 22** is an example of the Gateway EDI Clearinghouse Payer List for Wisconsin payers using the search options on **Figure 26**.

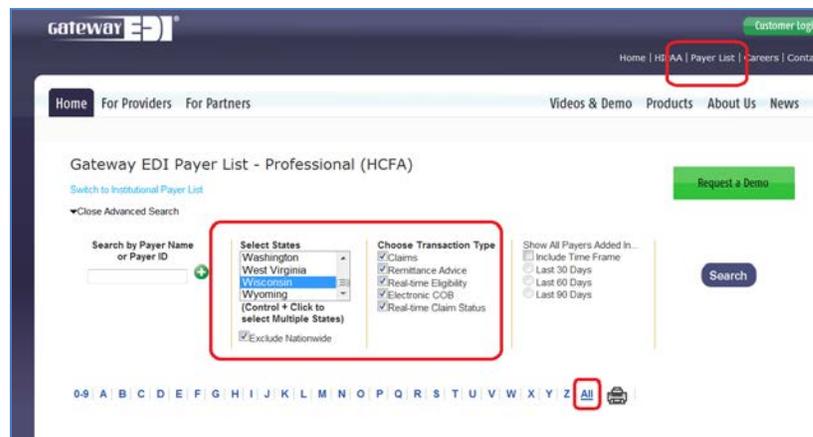


Figure 26 - Gateway EDI Clearinghouse Payer List Report

**Medicaid Note:** According to [DHS 106.03\(5\)\(c\)2](#), Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

