Podcast Transcript

Title: ICD-10-CM Codes for Contraceptive Management Updated for October 1, 2016 Changes
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NCTCFP: Welcome to this podcast sponsored by the National Clinical Training Center for Family Planning. The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest speaker today is Ann Finn from Ann Finn Consulting, LLC. Ann Finn is a healthcare reimbursement consultant and a national trainer with many reproductive health care organizations. Welcome, Ann!

Ann Finn: Thank you very much for the introduction and thanks for joining us. Today's podcast will focus on applying ICD-10 diagnosis codes to common contraceptive visits. We've included some recent updates that went into effect as of October 1, 2016 so make sure to share this information with your clinical and billing staff.

ICD-10 stands for the International Classification of Diseases 10th Revision, which is an update to the old ICD-9 code set we used for many years. The United States implemented ICD-10 on October 1, 2015.

ICD-10 diagnosis codes are used to describe ***the WHY services were provided*** - defining diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Although reimbursement is typically based on procedure codes, diagnosis codes also must be included on a claim to establish medical necessity and ensure accurate reimbursement.

As you may recall under ICD-9, contraceptive management codes fell into the family of codes under V25. Now that ICD-10 has been implemented, V25 codes are still active but have a completely different meaning. Be careful, V25 now describes a motorcycle rider injured in a collision with a railroad vehicle.

So where do we find contraceptive management codes under ICD-10? We now look to the Z30 family of codes. Remember, Z codes are the new V codes under ICD-10! I want to point out that Z00 through Z99 are codes representing factors influencing health status and contact with health services. Per ICD-10 official guidelines, Z codes are used in any healthcare setting and may be used as either a first-listed or secondary code, depending on the circumstances of the encounter.

Let's meet our patient, Abbey, who is sexually active and is seeking a new method of birth control. She is not sure what method of contraception she would like so she and the medical provider discuss the variety of birth control methods available, their effectiveness, and the potential side effects. After discussing these options, she decides she would like an IUD. Abbey is given a urine pregnancy test, which is negative. The

provider is able then to successfully insert the IUD. What ICD-10 codes would you use to describe this visit?

First we would select Z30.09 Encounter for other general counseling and advice on contraception, to support the contraceptive options counseling. This is important to code if we are billing for the contraceptive counseling separate and distinct from the insertion procedure codes for IUDs and implants.

We would also need a code to support the medical necessity of the urine pregnancy test so that we can bill and get paid for our point of care laboratory test done during this visit.

There are now 3 codes for pregnancy tests results. The Z32.00 for unknown result, Z32.01 for the positive result, and Z32.02 for a negative result. In this case, we would select the Z32.02 for a negative result. Remember, there should be a basis for performing any lab tests documented in the medical record.

What about the IUD insertion? We would select Z30.430 Encounter for IUD insertion to support the insertion procedure being done and the LARC device.

Other common ICD-10 codes related to the IUD include:

- Z30.431 Encounter for routine checking of the IUD or a surveillance visit
- Z30.432 for the IUD removal
- Z30.433 for the removal and the reinsertion of an IUD
- Z30.014 Encounter for the initial prescription of an IUD which is used if you are prescribing the IUD, but not actually inserting the device during this visit. An example of this is when a clinician and a patient decide on an IUD, but the device needs to be ordered through a pharmacy benefit and will be inserted at a later visit. There is a coding exclusion noted in ICD-10 to not use this code on the same encounter as the IUD insertion code Z30.430.
- And finally, Z30.012 if the patient is getting a copper IUD as emergency contraception or EC. One note about IUDS as EC, to avoid reimbursement issues, I recommend checking with your payers ahead of time to confirm if they would require both the Z30.430 IUD insertion code and the Z30.012 for the EC, or if you can just include the one code for EC.

What if there was a mechanical issue with the IUD? We would choose a code from the family of codes under T83.3—for Mechanical complications of IUDs. An example would be a code T83.32xA for an initial encounter of a displacement of the IUD or a missing IUD string.

What if Abbey is here for her GYN well visit and also has an implant or Nexplanon inserted? For the GYN exam portion, we now have 2 codes to choose from under ICD-10, which also holds true for other general exam codes such as a well child or routine adult codes:

- Z01.411 Encounter for the GYN exam ***with*** abnormal findings, or
- Z01.419 Encounter for the GYN exam ***without*** abnormal findings

How do we choose between the 2 codes? Remember, the exam code is dependent on what is known at the time of the encounter. Chronic conditions should not be considered "abnormal findings" unless a change in their status has occurred. If there are abnormal findings during the exam, such as a breast lump that is further evaluated, code with abnormal findings and any additional codes needed to describe the finding. If there are no abnormal findings at the exam, but subsequent test results shows an abnormality, report *without* abnormal findings for visit, and the subsequent visits we would follow up with will include code for the condition. Again, code what is known at the time of the encounter.

For the first release of ICD-10 that was effective through September 30, 2016, there were no unique codes for implants, and we were told to use either Z30.018 for the implant insertion and Z30.49 for the routine checking, removals or reinsertion of the implant. However, CMS released an update to the ICD-10 codes that went into effect October 1, 2016. This update included 2 new codes for implant contraceptives:

- Z30.017 For the insertion of the implant, and
- Z30.46 for the routine checking, removals and reinsertions of the implant

Again, these are new codes that went into effect October 1, 2016 so make sure your systems and claims are updated with these new codes.

What if Abbey presents wanting oral contraceptives or the pill? We would choose the unique method code Z30.011 Encounter for initial prescription of contraceptive pills and then the Z30.41 for pill surveillance and refill visits. Other related codes would include:

- Z79.3 Long term (current) use of hormonal contraceptives, or
- T38.4 family of codes related to poisoning by, adverse effect of and under dosing of oral contraceptives. An example here would be if Abbey was prescribed birth control pills and a week later she comes in complaining of severe abdominal pain. The provider determines she is having an adverse effect from the prescribed pills. For this situation you would use code T38.4x5A, adverse effect of oral contraceptives initial encounter, along with the code describing the abdominal pain.

Injectable contraceptives such as DMPA have a new unique codes under ICD-10 as well. Use Z30.013 Encounter for initial prescription of injectable contraceptive and Z30.42 Encounter for surveillance or refill for the injectable contraceptive visit.

Vaginal rings, hormone patches and other barrier methods had no unique method codes under the first release of ICD-10 just like the implants I mentioned. So, for any claims through September 30, 2016, we would use the generic "other contraceptive" codes Z30.018 for initiating these methods, or Z30.49 for their refill visits.

However, CMS did release new codes for vaginal rings and hormonal patches that went into effect October 1, 2016. For vaginal rings, we now select:

- Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive for when you start this method for a patient, or
- Z30.44 Encounter for surveillance of a vaginal ring hormonal contraceptive for the checking and refill visits

If we prescribe the hormonal patch as her method we would use the new codes:

- Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device, or
- Z30.45 for the checking and refill visits

Use code Z30.012 for the emergency contraception visit including both oral EC and the copper IUD.

Perhaps Abbey was seeking counseling and instruction in natural family planning to avoid pregnancy, in this case, we pick the specific code for the natural family planning method Z30.02. If Abbey presented for tubal or sterilization, we would code the appropriate surgical procedure along with Z30.2 Encounter for sterilization

The codes Z30.018 and Z30.49 are still active ICD-10 codes for contraceptive management, but the descriptors have been clarified for each code as of this October. Z30.018 now includes the descriptors:

- Encounter for initial prescription of barrier contraception (meaning condoms, sponges, spermicides, etc.), or
- Encounter for initial prescription of diaphragm, and
- Z30.49 which has been updated to reflect that it can be used specifically for checking and refills condoms, sponges, spermicides or diaphragms etc. The descriptors now include:
    - Encounter for surveillance of barrier contraception or
    - Encounter for surveillance of diaphragm

It seems like a lot of codes to remember, but keep in mind there are now specific codes for each method and whether or not we are starting a method or providing a refill. We've also provided a helpful pocket reference coding card for contraceptives on our website for you to download as well.

So let's wrap up. ICD codes explain why the services were provided and support medical necessity. Be specific in both your chart documentation and your code selection for each contraceptive method and services provided. Use different codes for initiating the method and refills or surveillance visits. Avoid unspecified codes when possible. Contraceptive management codes all start with Z30. Ensure your EHR and all systems are up-to-date with these latest codes and reimbursement is not impacted by any of these changes or inactive codes. ICD-10 coding is still relatively new to most clinicians and billers. We all still need continued support for a long-term successful transition. Chart and remittance reviews, follow-up training, and feedback are all essential steps to protecting coding compliance and revenue in your practice.

Thanks for joining us today.

NCTCFP: Thank you, Ann, for this information. For more training information and resources on coding in family planning settings, please visit the National Training Centers' website at www.fpntc.org or call the National Clinical Training Center for Family Planning at 1-866-91-CTCFP, that's 1-866-912-8237. Thank you.