From V Codes to Z Codes: Transitioning to ICD-10 (Updated)

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Editor's note: This column supercedes the February 2004 article "From V Codes to Z Codes: Transitioning to ICD-10."

V codes, described in the ICD-9-CM chapter "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services," are designed for occasions when circumstances other than a disease or injury result in an encounter or are recorded by providers as problems or factors that influence care. Under ICD-10-CM, these services will be reported under a new set of codes-Z codes.

According to National Center for Health Statistics data on ambulatory medical care utilization, V codes were reported as the primary reason for approximately 20 percent of all ambulatory care visits to physician offices, hospital outpatient departments, and hospital emergency departments.[1] The top V codes reported as the first-listed diagnosis for ambulatory medical services include routine infant or child health check (V20.1), general medical examination (V70), normal pregnancy (V22), follow-up examination (V67), gynecological examination (V72.3), and potential health hazards related to personal and family history (V10–V19).[2]

V Codes in ICD-9-CM

The October 1, 2011, ICD-9-CM Official Guidelines for Coding and Reporting, include coding guidelines for V codes throughout sections I–IV. Section I C, "Chapter-Specific Coding Guidelines," specifies that unless otherwise indicated, the coding guidelines for this section apply to all healthcare settings. The guidelines are available on the National Center for Health Statistics Web site at www.cdc.gov/nchs/icd/icd9cm.htm.

Section I C.18, titled "Classification of Factors Influencing Health Status and Contact with Health Service," provides specific coding guidelines for the use of V-code categories V01–V91. V codes in section II, "Selection of Principal Diagnosis," and section III, "Reporting Additional Diagnoses," apply to inpatients in acute care, short-term, long-term care, and psychiatric hospital settings. Section IV, "Diagnostic Coding and Reporting Guidelines for Outpatient Services," provides V-code instructions for the outpatient and physician office setting. The outpatient setting includes reporting by home health agencies.

Changes in ICD-10-CM

The ICD-9-CM V-code coding guidelines included in this article preview coding practices in ICD-10-CM for factors influencing health status and contact with health services. The coding guidelines between the two coding classification systems are the same unless otherwise specified.

A significant change between the two coding classifications is that ICD-9-CM's supplementary codes are incorporated into the main classification in ICD-10-CM. The ICD-10-CM Tabular List categorizes codes to represent reasons for encounters as Z codes instead of V codes. ICD-10-CM codes have three to seven characters, but Z-code categories Z00–Z99 consist of three to six characters. Additional ICD-10-CM information is available on the National Center for Health Statistics Web site at www.cdc.gov/nchs/icd/icd10cm.htm.

Screening, Routine Examination

Screening visits provide asymptomatic individuals with early detection testing for diseases such as a screening mammogram used in the early detection of breast cancer in women. Screening codes can be used as either a first-listed or additional code

depending on the reason for the encounter. If the reason for the encounter is specifically the screening exam, the screening code is the first-listed code and any condition discovered during the screening may be listed as an additional diagnosis.

A procedure code is required to validate the screening exam. Screening visit codes do not apply when a physician orders a diagnostic test for an individual based on a suspected abnormality, sign, or symptom. For these visits, the sign or symptom is used to report the reason for the test (see the table "Outpatient Facility-Screening Scenario," below).

Routine and administrative examinations are performed without relationship to treatment or diagnosis of an illness or symptom or at the request of third parties such as employers or schools. Routine examination codes should be used as first-listed codes only. This category should not be used if the examination is for diagnosing a possible condition or for providing treatment. Instead, a diagnosis, sign, or symptom code is used to report the reason for the visit.

Codes in ICD-10-CM categories Z00 and Z01, Persons encountering health services for examinations, are available when the encounter is for an examination "with abnormal findings" and "without abnormal findings." A note instructs the coder to use an additional code to identify any abnormal findings based on the results of the examination.

Outpatient Facility-Screening Scenario

Asymptomatic 67-year-old female patient presents to the outpatient radiology department for a bilateral mammogram. The physician's order documented breast cancer screening. The radiology report notes clusters of microcalcification in the left breast.

First-Listed Diagnosis	ICD-9-CM	V76.12 Other screening mammogram
	ICD-10-CM	Z12.31 Encounter for screening mammogram for malignancy of breast
Additional Diagnosis	ICD-9-CM	793.81 Mammographic microcalcification
	ICD-10-CM	R92.0 Mammographic microcalcification found on diagnostic imaging of breast
Procedure	CPT	77057 Screening mammography, bilateral

Physician Office-Routine Exam Scenario

45-year-old established patient presented to her physician's office for a routine physical exam. During the examination the physician identified an enlarged thyroid. The physician ordered a laboratory test and requested to see the patient in two weeks.

First-Listed Diagnosis	ICD-9-CM	V70.0 Routine general medical examination at a healthcare facility
	ICD-10-CM	Z00.01 Encounter for general adult medical examination with abnormal findings
Additional Diagnosis	ICD-9-CM	240.9 Goiter, unspecified
	ICD-10-CM	E04.9 Nontoxic goiter, unspecified

Aftercare versus Follow-up Visits

Aftercare codes identify specific types of continuing care after the initial treatment of an injury or disease. V-code subcategories for orthopedic aftercare (V54.1 and V54.2) specify encounters following initial treatment of fractures. Coding guidelines state that a fracture code from the main classification can be used only for an initial encounter. Subsequent encounters that usually occur in an outpatient, home health, or long-term care facility now have the ability to report the type and site of fractures within the new subcategory sections.

Orthopedic aftercare visit coding guidelines differ in ICD-10-CM in that Z codes should not be used if treatment is directed at the current injury. If treatment is directed at the current injury, the injury code should be reported with a seventh-character extension to identify the subsequent encounter. The purpose of assigning the extension is to be able to track the continuity of care while identifying the type of injury.

While aftercare codes are used for a resolving or long-term condition, follow-up codes are used for conditions that require continuing surveillance following completed treatment of a disease, condition, or injury. ICD-9-CM coding guidelines state that follow-up codes are listed first unless a condition has recurred on the follow-up visit, then the diagnosis code should be listed first in place of the follow-up code.

Home Health-Aftercare Visit Scenario

74-year-old patient fell at home and sustained a subtrochanteric fracture of the left femur and was discharged home. Physician ordered physical therapy for difficulty in walking and exercise three times a week for one month.

First-Listed Diagnosis	ICD-9-CM	V57.1 Other physical therapy
	ICD-10-CM	S72.22xd Displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing
Additional Diagnosis	ICD-9-CM	719.7 Difficulty in walking V54.13 Aftercare for healing traumatic fracture of hip
	ICD-10-CM	R26.2 Difficulty in walking, not elsewhere classified

Inpatient, Acute Care-Status Scenario

A 54-year-old male is admitted into the hospital with a principal diagnosis of surgical site infection secondary to a recent right side below the knee amputation. Patient is a type I diabetic with diabetic peripheral vascular disease and congestive heart failure. The patient sought treatment when the wound began to exude purulent drainage. On the second day of his hospitalization he had developed nausea, uncontrolled diabetes, and ketoacidosis.

Moist saline dressings were applied twice daily to the wound. Wound culture tested positive for Staphylococcus aureus and was resistant to flucloxacillin. Ciprofloxacin effectively treated the infection. Diabetic ketoacidosis managed well and blood glucose was brought under control. Patient was discharged to a rehabilitation facility for continued wound management.

Principal Diagnosis	ICD-9-CM	997.62 Amputation stump infection
	ICD-10-CM	T87.43 Infection of amputation stump, right lower extremity
Additional Diagnosis	ICD-9-CM	041.11 Staphylococcus aureus V09.0 Infection with microorganisms resistant to penicillins 250.13 Diabetes with ketoacidosis 250.73 Diabetes uncontrolled with peripheral circulatory disorders

		443.81 Peripheral angiopathy in diseases classified elsewhere 428.0 Congestive heart failure, unspecified
	ICD-10-CM	B95.6 Staphylococcus aureus as the cause of diseases classified elsewhere Z16 Infection with drug-resistant microorganisms E10.10 Type 1 diabetes mellitus with ketoacidosis without coma E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene I50.9 Congestive heart failure, NOS

History, Status Codes

Personal and family history codes are acceptable to report regardless of the reason for the visit. A personal health history of an illness that no longer exists is important since this information may alter the type of treatment ordered. Family history codes are reported when a family member of an individual has had a particular disease that links the patient to be at higher risk of also contracting the disease. Personal and family history codes support the need for screening and follow-up exams.

The Centers for Medicare and Medicaid Services requires reporting history V codes for certain preventive services such as ultrasound screening for abdominal aortic aneurysm, Pap tests, pelvic exams, and colon cancer screenings. CMS's coding policies are available at www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.

Status codes are informative; however, they are distinct from history codes. Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing his or her health status.

Since status codes may affect the course of treatment and its outcome, the codes are used to track public health issues. For example, the status codes for infection with drug-resistance microorganism are assigned as an additional code for infectious conditions to indicate the presence of the drug-resistant infectious organism (see "Inpatient, Acute Care-Status Scenario").

Outpatient Prenatal Visits

In ICD-9-CM a code from category V23, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis for routine prenatal outpatient visits for patients with high-risk pregnancies unless a pertinent tabular category V23 exclude note applies. When appropriate, secondary chapter 11 codes may be reported with category V23 codes.

In contrast, ICD-10-CM does not include Z code prenatal visits for supervision of high-risk pregnancy. Rather, routine prenatal outpatient visits for patients with high-risk pregnancies are assigned a code from chapter 15, category O09, Supervision of high-risk pregnancy, as the first-listed diagnosis.

Notes

1. Schappert S.M., and E.A. Rechtsteiner. "Ambulatory Medical Care Utilization Estimates for 2007." Vital and Health Statistics 13, no. 169 (April 2011). www.cdc.gov/nchs/data/series/sr_13/sr13_169.pdf.
2. Ibid.

References

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Article citation:
Kostick, Karen M.. "From V Codes to Z Codes: Transitioning to ICD-10 (Updated)" *Journal of AHIMA* 82, no.11 (November 2011): 60-63.