From V Codes to Z Codes: Transitioning to ICD-10

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V codes, described in the ICD-9-CM chapter "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services," are often misunderstood in reporting healthcare services. These codes 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.

ICD-9-CM codes such as V01.82, Exposure to SARS—associated coronavirus, and V01.81, Contact with or exposure to anthrax, are examples of how V codes capture significant US healthcare statistics. Although health plans have sometimes been reluctant to accept V codes as justification for reimbursement, these codes play a key role in classifying selected services and capturing important information.

Under ICD-10-CM, these services will be reported under a new set of codes—Z codes—with some significant changes.

V Codes in ICD-9-CM

The official coding guidelines that became effective on October 1, 2002, include coding guidelines for V codes throughout Sections I-IV. Section I C, "Chapter or Disease Specific Coding Guidelines," includes a clarification note for coders and states that unless otherwise indicated, the coding guidelines for this section apply to all healthcare settings. Complete copies of the guidelines are available from the National Center for Health Statistics (NCHS) Web site at www.cdc.gov/nchs.

Section I includes a new section titled "Classification of Factors Influencing Health Status and Contact with Health Service (C-18)." This section provides coding guidelines for frequently used V code categories. V codes reviewed in Section II, "Selection of Principal Diagnosis(es)," and Section III, "Reporting Additional Diagnoses," apply to the inpatient, short-term acute care setting. 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 selected 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 in general may have up to seven characters, but Z codes under categories Z00-Z99 consist of three to six character codes. Additional ICD-10-CM information is available for downloading from the NCHS Web site.

Screening, Routine Examination

Screening visits provide healthy patients early detection tests such as a mammogram or a colonoscopy. 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 diagnostic test is ordered for a patient to evaluate a complaint or an abnormality detected by a physician. For these visits, the sign or symptom is

used to report the reason for the test. (See "Outpatient Facility—Screening Scenario").

Routine and administrative examinations are performed without relationship to treatment or diagnosis of an illness or symptom, or performed 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 sign or symptom code is used to report the reason for the visit.

Codes within 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.

Aftercare Versus Follow-up Visits

Aftercare codes identify specific types of continuing care after the initial treatment of an injury or disease. In 2002, two V code subcategories for orthopedic aftercare (V54.1 and V54.2) were added to specify encounters following initial treatment of fractures. Coding guidelines state that a fracture code from the main classification can only be used 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 an extension as the seventh character to signify 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 have completed treatment or for cancer patients to monitor the recurrence of cancer after treatment has been completed. 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. ICD-10-CM coding guidelines differ in that if a condition is found to have recurred on a follow-up visit, the follow-up code is still used and the diagnosis code is listed second. Personal history codes should be assigned as an additional code with follow-up examinations.

History, Status Codes

Personal and family history codes are important pieces of information that support the need for screening exams and follow-up exams. The Centers for Medicare and Medicaid Services (CMS) requires history V codes when appropriate in conjunction with mammograms, Pap tests, pelvic exams, and colon cancer screenings. You can read the CMS coding policies at: www.cms.hhs.gov/medlearn/womens_health.pdf.

Some status codes support increased healthcare costs, as the status can affect the treatment plans and its outcome as noted in the official coding guidelines. Status codes can also be 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 drug-resistance of the infectious organism. It is evident ICD-10-CM offers additional codes and a greater level of specificity to report health status and contact with health services in the revised classification. However, in a couple areas, ICD-9-CM is more specific than ICD-10-CM, as noted in "Inpatient, Acute Care—Status Scenario," with regard to the ICD-10-CM category for infection with drug-resistance microorganisms.

Outpatient Prenatal Visits

An area to pay close attention to when reporting prenatal visits in ICD-9-CM is category V23, Supervision of high-risk pregnancy. Coding guidelines for high-risk prenatal visits instruct that a code from category V23 be assigned as the first-listed or principal diagnosis unless a pertinent excludes note apply. If a V23 category excludes note applies codes from Chapter 11, Complications of Pregnancy, Childbirth, and the Puerperium Chapter (630-677) may be listed as a first listed or principal diagnosis code.

If appropriate, Chapter 11 codes may be assigned as additional codes with category 23. ICD-10-CM does not include codes for supervision of high-risk pregnancy in the chapter to report factors influencing health status and contact with health services

(Z00-Z99). Rather, these codes are incorporated in the chapter for conditions related to pregnancy and childbirth. ICD-10-CM high-risk pregnancy codes are available for patients who have had complications in the past and are categorized by first, second, and third trimester.

Advocating Coding Consistency

The HIPAA standard transactions and code sets regulation includes a requirement that the official coding guidelines are used along with ICD-9-CM for reporting. This represents an important step in the adoption of uniform code reporting requirements across all payers. Coding for reimbursement is addressed in the American Hospital Association's (AHA) 2000 3rd Quarter *Coding Clinic*, including problems that arise between providers and payers in relation to coding guidelines and payer coding policies.

AHA provides helpful tips on how to effectively settle coding conflicts with payers. When payers deny a particular claim, it is recommended that you first identify whether it is really a coding conflict and not a coverage matter. A payer may be using the correct coding guidelines but may not be covering certain services such as a routine or follow-up examination.

If you determine that a health plan reporting policy conflicts with the official coding guidelines, AHA advises you to obtain the payer policy in writing and advocate adherence to official coding guidelines. Coding professionals may influence the fiscal intermediary or carrier to apply official coding guidelines to ensure reliable claims data. These coding practices are also referenced in the AHIMA Standards of Ethical Coding.

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:	76092 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:	Z00.011 Encounter for general medical examination with abnormal findings
Additional Diagnosis	ICD-9-CM:	240.9 Goiter, unspecified
	ICD-10-CM:	E04.9 Nontoxic goiter, unspecified

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
	ICD-10-CM:	V54.13 Aftercare for healing traumatic fracture of hip 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 Dx	ICD-9-CM:	
	ICD-10-CM:	997.62 Amputation stump infection T87.43 Infection of amputation stump, right lower extremity
Additional Dx	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

References

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