Medical Billing and the Use of Codes

ICD stands for the International Classification of Diseases. The current version is called ICD-9. ICD-9 codes are used to describe a patient’s diagnosis including symptoms, diseases or disorders. In a medical office, ICD-9 codes are used to establish medical necessity for patient visits as well as to communicate to insurance companies the reason for a patient visit.

It is important for ICD-9 codes to be accurate for the quality of patient care, to prevent medical malpractice and for the medical office to receive proper insurance reimbursement. Proper ICD-9 coding requires an understanding of how ICD-9 codes are used, how to use the ICD-9 manual and the importance of accuracy in ICD-9 coding.

To summarize, ICD-9 codes
• usually referred to as diagnosis codes
• stands for International Classification of Disease, Ninth Revision
• coding is a universal or standard system used for the purpose of identifying diseases
• are three, four or five digit codes
• can describe the reason for the visit, the illness, the injury or supplemental information
• can be numerical or alphanumerical
• must be coded to the highest level of specificity
• are listed on billing claim forms, CMS-1500 and UB-04

This system was started in 1979 and has been modified yearly since then. This coding system allowed for the use of a SuperBill. This was a single page that included the patient’s demographics, the medical office information such as address and medical license, the most commonly used procedures (CPT codes) used by the doctor and the most common diagnoses (ICD-9) used by the doctor. The number of disease codes could be as high as 135 and still fit a single page. Each listing would include the name of the disease or condition and the specific code that describe that diagnosis.

This thirty-five year old system is to be completely replaced on October 1, 2015. The general principles will not change. However, the ICD-9 code has about 14,000 codes and the codes are 3, 4 or 5 digits long. The new code starting in October will have 68,000 codes and these codes have 5, 6 or 7 digits. Many physicians feel that the advent of the Electronic Medical Records (EMR) system will do away with the SuperBill because paper forms may not be necessary. However, many physicians will still want to use a form of the SuperBill for several reasons. One is that the SuperBill may be placed outside the patient’s room for the doctor to use for identification purposes prior to entering the room. At the conclusion of the exam, it will also allow the doctor or tech to quickly circle or underline the codes generated for the visit even if that has been entered within the EMR system. This form will be taken with the patient to the checkout counter as the patient is being discharged. That will allow the check out staff to verify that the EMR and the doctor’s codes are consistent with each other.

So, what is the problem? The problem is that the new system has so many more codes and the new codes have 5, 6 or 7 digits compared to the old code of 3, 4 or 5 digits. The extra codes allow for greater specificity in describing the patient’s diagnoses. I am an Ophthalmologist and my examples described here are specific to Ophthalmology. However, the principles are universal and can be customized for any specialty. For example, it allows one to enter which eye or eyelid is involved with a specific diagnosis. That was not easy with the old ICD-9 system. This SuperBill system includes 95% (about 135) of the doctor’s most commonly used diagnoses and can still fit on a one-page SuperBill. The following details explain how this new system is able to identify the descriptive characteristics of these diagnoses.
The new coding system has several rules and several flaws.

It now has a schedule for naming which eye is used. The OD is 1, the OS is 2 and bilateral is 3. That is pretty simple.

For the eyelids, it is a little more complex. The Right Upper Eyelid is 1, the Right Lower Eyelid is 2, the Left Upper Eyelid is 4 and the Left Lower Eyelid is 5. They also have three useless codes: 3 is a right eyelid that is unspecified, 6 is a left eyelid that is unspecified and 9 is the eye and is unspecified. I cannot imagine why anyone would want to use 3, 6 or 9.

In addition to these codes, there are codes for injury encounters with the patient: Initial is A, Subsequent is D and Sequelae (seeing the patient for the late results from an injury) is S.

They also have codes for severity: mild is 1, moderate is 2 and severe is 3.

They included a space saver using the letter “X.” This is useful when a specific code descriptor can only be used as the seventh digit and there is no sixth digit. The X fills the sixth digit space. The X is also used for the replacement for the -59 modifier. XA is for a separate encounter. XS is for a separate structure. XP is for a separate practitioner. And XU is for an unusual nonoverlapping service.

The idea behind this SuperBill system is to assign a letter to be added at the end of a code on the SuperBill to notify the physician or the coder that additional identifiers are required. These additional letters provide a way for the physician or coder to complete the code for laterality, severity and sequence.

E is for which eye, L is which eyelid, Y is for severity and Z is for the Injury sequence.

So, a few examples: H25.1E is a nuclear sclerotic cataract for an eye and the reported code is H25.11 if it was the right eye. It could also be H25.13 for bilateral nuclear sclerotic cataracts.

H40.12EY is for Low Tension Glaucoma and requires an eye and severity. H40.1213 would be Low Tension Glaucoma for the right eye and it is severe.

T15.0EXZ is for a corneal foreign body with a specific eye and whether it is an initial injury encounter. The sequence code Z has to be the seventh digit. For an initial injury to a left eye, the code is T15.02XA. So, the code has a 2 for the left eye, an X for the sixth digit that is not present and an A for an initial injury encounter.

For other specialties, laterality would be for which arm, hand, kidney, lobe of the brain, lung, part of the heart, etc. Severity will also apply to any subspecialty condition. And, of course, the encounter sequence letter would apply to any part of the body that involved an injury initial or subsequent encounter or had an encounter for sequelae that followed an injury.

The Y and Z can be used for any specialty. As for laterality and specificity of which part for example, there could be H for hand, F for foot and C for Carotid artery. Each subspecialty would use the exact same form as for Ophthalmology, but they would just replace the E and L with representative letters for their specific needs. And, of course, they would determine which common diagnoses they want to list.

The letters can be changed. It is this system that allows the SuperBill to be used even with the 68,000 codes and the additional two digits required for the codes. There are at least five (5) other reasons why a SuperBill is more efficient than the EMR, by itself.

First, is education. It is much easier to train new and old staff with this system because everything they need is laid out in a logical and understandable order. There are not multiple screens or books that have to be used to identify the proper codes.
Second is communication. If you need to leave a note for the front staff such as requesting old records or calling a lab for results, there is space on the SuperBill to do just that. You place a couple of words or check the Obtain Old Records box and circle it. No one will miss that.

Third is entering the codes in the proper order. This SuperBill system more easily allows the staff to identify when a specific diagnosis is for a specific CPT (Current Procedural Technology) code. This can happen when an OCT laser scan was performed and the patient has two diagnoses of which only one is the diagnosis being used for that OCT CPT. For example, if an OCT scan was performed and the patient has both Diabetic Retinopathy and Age-Related Macular Degeneration diagnoses, we have to specify which diagnosis was used to justify the procedure. It is true that the OCT code 92132 (33 or 34) specifies whether it is of the anterior segment, optic nerve or macula. But, in this case, that code 92133 could be for either diagnosis. It is simple to either draw a line from the CPT code to the diagnosis code or label the CPT code with a number (like a 1 or a 2) that matches a similar number entered next to the diagnosis code. This is also used when a visual field test is performed for a patient taking Plaquenil in the treatment of Rheumatoid Arthritis. In that case, the reason for the testing is because Plaquesnil is labelled as a Long-Term, High-Risk medication. For billing purposes, the diagnosis of Long-Term, High-Risk is placed first and the disease code is always placed second. That is easier to show on the SuperBill than in the EMR where multiple diagnoses can seem to run together.

Fourth is quick information. This SuperBill system allows for a quick glance and all of the visit's information is available on that sheet. You do not need to have multiple EMR screens open to determine what is happening.

Fifth is patient education. This SuperBill also allows for easy identification of the proper educational handout to offer to the patient as they are leaving. The lower right-hand corner of the SuperBill lists abbreviations for the most common educational pamphlets we offer to patients. The staff person identifies the circled abbreviation and pulls out the appropriate pamphlet from the drawer next to her and quickly gives it to the patient. She does not have to look at the patient's summary, determine which pamphlet should be selected and then print it out for the patient. The SuperBill method is efficient and takes less time.

The following four pages show how I set up the actual SuperBill and how there is more than one way for the physician to identify the codes he wants his staff to use in the patient's billing process. The page set up is also a part of the system to allow for easily separating the 135 codes by anatomical or functional sectors that don't waste space but still distinctly identify different sectors, like Cornea, Retina, Eyelid and the others. Each section is separated from the next section by underlining the last line of the section. This allows the physician to quickly find the code he needs.

The SuperBill organization follows the Quick Reference Guide pattern in the Ophthalmology 2015 ICD-10 Coding book from the American Academy of Ophthalmology and you can quickly see the underlined codes that separate one section from the next. The first section includes codes describing what the patient complained about or why the patient came to the office. These are like blurred vision, dry eyes, vitreous floaters and headache. Every subspecialty has its own common patient complaints that bring their patients to the office. The SuperBill is easily customizable for any subspeciality. These complaint diagnoses could be duplicated in the appropriate specific section, but that is a waste of space. You quickly become comfortable looking for the common complaint section for these diagnoses and learn not to look in the specific sections to hunt for that code. For Ophthalmology, the more specific sections follow the patient complaint initial section and are Cataract, Conjunctiva, Cornea, Sclera, Eyelid, Glaucoma, Iritis, Optic Nerve, Retina, Muscles, Vision changes and a Miscellaneous section.
The top center section of the SuperBill includes reasons for return appointments, Meaningful Use codes, descriptions for each of the E, X, and Z descriptors and 4 boxes to enter diagnostic codes or their modifiers. Physicians use Meaningful Use codes for their specialty and three MU codes are listed here. As of late 2014, several more MU objectives are required. With abbreviations, additional MU codes can be entered in place of the three codes listed below.

The following four pages show samples of the SuperBill and of how the ICD-10 SuperBill is used with three different methods to enter the diagnostic codes and their modifiers.

### Sample SuperBill

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refraction</td>
<td>Q102.15</td>
</tr>
<tr>
<td>New Patient</td>
<td></td>
</tr>
<tr>
<td>CVN Complete</td>
<td>92004</td>
</tr>
<tr>
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<td>92002</td>
</tr>
<tr>
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<td>92002</td>
</tr>
<tr>
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<td>Z9503</td>
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</tbody>
</table>

### Establishment Patient

| CWO Complete | 92014 |
| RWI Intermediate | 92012 |
| CSOM Complete | 92012 |
| RSIM Intermediate | 92012 |

### Special Services

| VF Extended Full Thresh | 92083 |
| Topographic/Corneal | 92025 |
| OCT Opt N-Retina | 92133-134 |

### Office Surgery

| Chalazion excision x1 | 67800 |
| Chalazion exc multiple | 67801 |
| Corneal Debridement | 65435 |
| Excision lid lesion | 67840 |
| Exc benign lid tumor .5cm | 11440 |
| Exc malignant lid tumor .5cm | 11640 |
| Probe/irigate tear sac | 68840 |
| Punctum Plug Insertion | 68761 |
| Punctum plugs | Y4190 |
| Rem cong FB embedded | 65210 |
| Rem cong FB super | 65205 |
| Rem corneal FB embedded | 65222 |
| Trichiasis, epsilon | 67820 |
| Trichiasis, electrocautery | 67825 |

### Contact Lenses

| Contact lens evaluation | 92314 |
| Contact lens fit | 92307 |
| CL fit for disease | 92307 |
| Supply of Contact lenses | 92391 |
| Replacement of Contacts | 92326 |
| Contact lens mod | 92325 |

### Other Procedure

| Total Charges | $125.58 |

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### Other Procedure

| Total Charges | $125.58 |
The first method seen on this page shows three diagnosis code boxes having been checked and an arrow is run from each of the checked diagnoses to the appropriate diagnosis box above (the first, the second, the third or the fourth). In that box(es) above is entered the number or letter that describe either an E, L, X, Y and/or Z. The front staff would use the code checked and just replace the descriptor code with the number(s) entered in the box(es). This completed code would be entered into the computer.

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**Checked boxes, arrows and code descriptors**

**Procedure**
- CPT
  - Refraction: 92015
  - New Patient
    - ○ CWN Complete: 92004
    - ○ CNSM Complete: 92004
    - ○ NSM Intermediate: 92002
    - ○ C/Ref/Medicaid: Z9503

**Special Services**
- ○ VF Extended Full Thresh: 92083
- ○ Topography/Corneal: 92025
- ○ OCT Opt N-Retina: 92133-134

**Office Surgery**
- ○ Chalazion excision x1: 67800
- ○ Chalazion exc multiple: 67801
- ○ Corneal Debridement: 65435
- ○ Excision lid lesion: 67840
- ○ Exc conjunctivum lid tumor: 11440
- ○ Exc malig conjunctivum lid tumor: 11640
- ○ Probe/irrigate tear sac: 68840
- ○ Punctum Plug Insertion: 67861
- ○ Punctum plugs: Y4190
- ○ Rem conj FB embedded: 65210
- ○ Rem conj FB super: 65205
- ○ Rem cornea FB embedded: 65222
- ○ Trichiasis, epilation: 67820
- ○ Trichiasis, electrocautery: 67825

**Contact Lenses**
- ○ Contact lens evaluation: 92314
- ○ Contact lens fit: 92310
- ○ CL fit for: 92070
- ○ Supply of Contact lenses: 92391
- ○ Replacement of Contacts: 92326
- ○ Contact lens modif: 92325

**Other Procedure**
- ○ Total Charges: $____

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**Return:**

- C1 [ ] C2 [ ] VF [ ] VFCE [ ] OCT [ ] OCTCE [ ]
- CL12 [ ] RC 3-6 [ ] GL 3-6 [ ] NCPC [ ]

**Schedule:**
- ___ Days ___ Weeks ___ Months
- Order contacts [ ] Get old records

**Plan:**
- Form of Care:
  - C: 1
  - C: 2
  - F: 1
  - F: 2
  - C: 4

**Return:**

- C1 [ ] C2 [ ] VF [ ] VFCE [ ] OCT [ ] OCTCE [ ]
- CL12 [ ] RC 3-6 [ ] GL 3-6 [ ] NCPC [ ]

**Plan:**
- Order contacts [ ] Get old records

**Return:**

- C1 [ ] C2 [ ] VF [ ] VFCE [ ] OCT [ ] OCTCE [ ]
- CL12 [ ] RC 3-6 [ ] GL 3-6 [ ] NCPC [ ]

**Plan:**
- Order contacts [ ] Get old records

---

**Special Services**
- ○ VF Extended Full Thresh: 92083
- ○ Topography/Corneal: 92025
- ○ OCT Opt N-Retina: 92133-134

**Office Surgery**
- ○ Chalazion excision x1: 67800
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**Contact Lenses**
- ○ Contact lens evaluation: 92314
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- ○ CL fit for: 92070
- ○ Supply of Contact lenses: 92391
- ○ Replacement of Contacts: 92326
- ○ Contact lens modif: 92325

**Other Procedure**
- ○ Total Charges: $____

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**Diagnosis**

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<tr>
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<td>OCTCE</td>
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<tr>
<td>CL12</td>
<td>RC</td>
</tr>
<tr>
<td>GL</td>
<td>NCPC</td>
</tr>
</tbody>
</table>

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**Summary**
- ○ Vis FL [ ] Cat
- ○ Mac Deg jDiab [ ] Amsler G
- ○ HA [ ] Migraine
- ○ GL [ ] Dry Eye [ ] Det Ret
This page has the same three diagnostic code boxes checked and shows a different method for entering the diagnoses. The actual full code is entered in the appropriate box above with the code and the proper additional descriptive number or letter to satisfy the laterality, sequence or severity. In this case, the order of the diagnoses is known by which box the codes were entered.

### Patient Information
- **Physician**
- **Location**
- **Appt. Date**
- **Appt. Resource**
- **Appt. Location**
- **Patient Last Name**
- **Acct_LastName**
- **Appointment Time**
- **Last visit DX code**
- **DI Code**
- **Patient Balance/Acct.Total Bal**
- **Acct._LastName**
- **Acct First Name**
- **Acct_Start**
- **DI Description**
- **Acct.PatientBal**
- **Account #**
- **Acct_Account**
- **Appointment Category**
- **M/F**
- **Insurance Primary Name**
- **Pl_Name**
- **Acct_Age**
- **Acct_Name**
- **Age**
- **Acpt.Memo**
- **Ticket # SuperbillNum**
- **Patient Fee Sheet**
- **Plan:**
- **Schedule:**
  - **Days**
  - **Weeks**
  - **Months**

### Procedure
- **CPT**
- **Refraction**
- **92015**

### New Patient
- **CWN Complete**
- **92004**
- **NSI Intermediate**
- **92002**
- **CSNM Complete**
- **92004**
- **NSIM Intermediate**
- **92002**
- **C/Ref/Medicaid**
- **Z9503**

### Established Patient
- **CWO Complete**
- **92014**
- **RWI Intermediate**
- **92012**
- **CSOM Complete**
- **92014**
- **RSIM Intermediate**
- **92012**

### Special Services
- **VF Extended Full Thresh**
- **92083**
- **Topography/Corneal**
- **92025**
- **OCT Opt N-Retina**
- **92133-134**

### Office Surgery
- **Chalazion excision x1**
- **67800**
- **Chalazion exc multiple**
- **67801**
- **Corneal Debridement**
- **65435**
- **Excision lid lesion**
- **67840**
- **Exc. benign lid tumor.5cm**
- **11440**
- **Exc. malig lid tumor.5cm**
- **11640**

### Procedure
- **Pitch/irrigate tear sac**
- **68840**
- **Punctum Plug Insertion**
- **68761**
- **Punctum plugs**
- **Y4190**
- **Rem conj FB embedded**
- **65210**
- **Rem conj FB super**
- **65205**
- **Rem corneal FB embedded**
- **65222**
- **Trichiasis, epilation**
- **67820**
- **Trichiasis, electrocautery**
- **67825**

### Contact Lenses
- **Contact lens evaluation**
- **92314**
- **Contact lens fit**
- **92310**
- **CL fit for disease**
- **92070**
- **Supply of Contact lenses**
- **92391**
- **Replacement of Contacts**
- **92326**
- **Contact lens modif**
- **92325**

### Other Procedure
- **Total Charges**
- **$**

### Checked boxes and full codes
- **Drusen Optic Nerve**
- **H47.32E**
- **Optic Neuritis**
- **H46.0E**
- **Retrolubular Neuritis**
- **H46.1E**
- **Differential neoplastic benign**
- **D35.2**
- **Asteroidal Hyalitis**
- **H43.2E**
- **Central Serous C Retinop**
- **H35.71E**
- **Choroidal scar unspec**
- **H31.00E**
- **Chorioretinal scar pos. pole**
- **H31.00E**
- **Cotton wool spots**
- **H35.81**
- **Cystoid Mac Edema**
- **H59.00X**
- **Detachment partial**
- **H33.01E**
- **DM Tili complication**
- **E11.9**
- **DM Tili complication**
- **E10.9**
- **DM I nonprof mild w ME**
- **E10.321**
- **DM I nonprof Mild s ME**
- **E10.329**
- **DM I nonprof mild s ME**
- **H31.122**
- **DM I nonprof mild s ME**
- **H31.129**
- **DM I nonprof mod s ME**
- **H31.139**
- **Insulin current-after code**
- **Z79.4**
- **Epiretinal Membrane**
- **H53.37E**
- **Retinal Hemorrhage**
- **H53.6E**
- **Retinal Exudates**
- **H53.89**
- **Lattice Degen**
- **H53.41E**
- **ARM Dry**
- **H35.31**
- **ARM Wet**
- **H35.32**
- **Macular Drusen**
- **H35.36E**
- **Macular holecytosis**
- **H35.34E**
- **Choroidal Neuvus**
- **H31.3E**
- **BRAG**
- **H33.23E**
- **BRV**
- **H34.63E**
- **Retinal detachment single**
- **break 230.20E**
- **Retinal detachment**
- **serous 230.22E**
- **Retinal horsehoe tear s detach**
- **230.31E**
- **Retinal round hole s detach**
- **230.35E**
- **Vitreous detach / degen**
- **H43.81E**
- **Vitreous hemorrhage**
- **H43.1E**
- **RPE detachment**
- **971.42E**
- **Retina Pigmentar**
- **H35.52**
- **6th CN palsy**
- **H49.2E**
- **Esophoria**
- **H50.51**
- **Exotropia monoculaire**
- **H50.01E**
- **Exotropia alternating**
- **H50.05**
- **Exophoria**
- **H50.52**
- **Exotropia monoculaire**
- **H50.11E**
- **Exotropia excentrique**
- **H50.15**
- **Hyperkeratosis**
- **H50.2E**
- **Thyroid Ophthalmopathy**
- **H50.05E**
- **Nystagmus congenital**
- **H55.01**
- **Amblyopia ref**
- **H53.02E**
- **Amblyopia strab**
- **H53.03E**
- **VF detect accuate/sector**
- **H53.43E**
- **VF detect centralpap**
- **H53.41E**
- **VF detect homonymous**
- **H53.46E**
- **Visual field detect geni constrict**
- **H53.48E**
- **Achromatopsia**
- **H53.51**
- **Mydriasis**
- **H57.04E**
- **Photopsia bulb**
- **H52.52E**
- **Long-term, high-risk med**
- **Z79.89**
- **Rheumatoid Arthritis**
- **M06.9**
- **Systemic Lupus**
- **L03.0**
- **7th CN Bell's Palsy**
- **G15.10**
- **Human Immunodeficiency Virus**
- **B20**

### Summary
- **Vit FL**
- **Cat**
- **Mac Deg Diab**
- **Amsler G**
- **HA**
- **Maign**
- **GL**
- **Dry Eye**
- **Det Ret**
**Numbered checked boxes and code descriptors**

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