

**USACHPPM
Technical Guide 249**

**Version 2
March 2000**

The **CODING BOOK** for
Occupational and Environmental
Medical Practices

Approved for public release; distribution unlimited.

CHAPTER 1: HISTORICAL OVERVIEW WITH THE BASIC CONCEPTS OF CODING

1-1. WORKLOAD RECORDING VERSUS SERVICE IDENTIFICATION.

a. For two decades military clinics have used the Medical Expense Performance Recording (MEPR) System for tracking workload. Under this system physicians, nurses, and ancillary staff recorded their workload in terms of patient visits. The aim of MEPR was to track workload so that the Military Treatment Facility (MTF) can receive reimbursement for the accumulated workload of all their staff personnel. Under MEPR the reimbursement varied with the workload.

b. The late 1990's brought the concept of capitation as a method for allocating health care resources. With capitation a MTF receives reimbursement based on the number of patients in its catchment area. The aim of each clinic is to efficiently supply services without exceeding the capitated dollars for each patient. Capitated reimbursement, with its emphasis on services appropriate for the patient's care, requires a coding system that reflects services provided rather than workload.

c. While MEPR is a military-unique method for recording workload, the commonly accepted method for receiving reimbursement from civilian insurance carriers uses Current Procedural Terminology (CPT) and International Classification of Disease (ICD-9) codes. The basic model for this coding system is a patient visit to the provider. A billable event arises when a patient receives care from the provider. Emphasis is on the services provided in the context of the doctor-patient visit. Workload to support the service is a secondary issue. The physician receives reimbursement based on the complexity of the services provided the patient. Capitation encourages the providers and the entire clinic to efficiently provide services within the capitation rate allowed by the insurer.

d. Like other clinics in the Military Health Service System, the Occupational Environmental Medicine (OEM) practice must change from tracking workload to tracking services. With military OEM practices spread throughout the United States, Hawaii, and Europe, this change requires a major readjustment in thinking to effectively use, and subsequently manage with, CPT/ICD codes. Civilian practices started the transition to coding in earnest in 1992 when the Health Care Finan-

ing Administration (HCFA) required both the ICD and CPT on the HCFA-1500 form for Medicare reimbursement. This Code Book builds on the civilian experience by providing a consistent set of codes that most military OEM practices can adopt. The assumption is that the military clinics' use of these coding systems must be the same as their civilian counterparts.

e. Civilian practices have learned the dangers of both overcoding and undercoding (see historical review below). The Code Book builds on these experiences and teaches coding appropriate for the services provided. Like their civilian counterpart, military practices can be penalized for inaccurate coding. Both overcoding, using a code for a level of service higher than the one provided, and undercoding present risks to military clinics in the era of capitation. Overcoding presents a picture of the clinic as a high cost center for which a contractor could provide similar services at a lower cost. Undercoding, using a code lower than the level of service, invites an insurer to send to the clinic sicker patients so that reimbursement is lower than the services required. Coding becomes the language of finance used in selecting those services for outsourcing. Military providers must use the appropriate level of code to avoid consequences that their civilian colleagues have already experienced.

1-2. HISTORICAL PROSPECTIVE, ICD-9 and CPT.

a. The code for diagnosis is the ICD-9CM (clinical modification), the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The World Health Organization owns the copyright, but in the United States the HCFA and the National Center for Health Statistics (NCHS) oversee updates to the Code. The Veterans Administration started using the ICD for hospital indexing, but in 1977 the NCHS modified the existing ICD-9 to permit its application beyond basic health statistics. The result was the clinical modification to the basic ICD-9, called ICD-9CM. ICD-9 is synonymous with ICD-9CM in this document, which provides appropriate English language adjustments and permits classification of medical records. This code answers the question of "why"

Like other clinics in the Military Health Service System, the Occupational Environmental Medicine practice must change from tracking workload to tracking services.

ICD-9CM codes are the official code for diagnoses. V codes also serve to describe the reason for the visit such as Medical Surveillance Exam V70.5.

the practice provided a service to the patient. Both NCHS and HCFA update the ICD-9CM annually on 1 October.

b. ICD-9CM occupies a two-volume set, with the first volume the tabular or numeric listing and the second volume the alphabetic listing. HCFA guidelines for correct coding techniques, described in the first pages of the book, require the coder to first search Volume 2 for the descriptive term of the diagnosis. Associated with the term is a three- or four-digit number, which serves as the entry into Volume 1. The numeric volume lists general diagnosis as three-digit codes, with up to two additional digits after the decimal point for more specific subdivisions of the general diagnosis.

c. Associated with the numeric codes are V and E codes. The former describes health care visits for reasons other than specific complaints, such as a Driver's License Exam (V70.3) or a Medical Surveillance Exam (V70.5). V codes, like numeric codes, serve as diagnoses, but E codes do not. The E codes modify the diagnosis to describe the reason for an injury or illness. For example, the coded diagnosis 883.0E920.5 means a puncture wound to the finger (883.0) due to a hypodermic needle (E920.5).

d. CPT is a systematic listing and coding of procedures performed by physicians. The owner of the CPT Codes is the American Medical Association. In 1966 HCFA implemented Medicare, which under Part B reimbursed physicians for services to Medicare enrollees over age 65. In order to identify physician services, HCFA implemented the three-level Health Care Common Procedural Coding Systems (HCPCS, pronounced Hick...Pick). Level 1 HCPCS are the CPT Codes which were first introduced in 1965. These codes answer the question of "what" services the practice provided to the patient. The AMA updates the CPT codes annually on 1 January.

e. Unlike the diagnosis codes, CPT codes are all five digits, with decimal digits sometimes added as modifiers of the basic five-digit code. The first two digits indicate the specific type of service, such as the 70000 series for radiology, 92000 for ophthalmology, and 99000 for Evaluation and Management (E/M). This latter service reflects the diagnostic nature of the physicians' work and is among the most commonly used codes. Division of the 99000 series is into broad categories such as office visits, hospital visits, consultations, and preventive services. Codes 99201 through 99215 are the office or outpatient services codes. They are further divided into new patient codes, 99201 through 99205, and established patient codes, 99211 through 99215. By contrast, age of pa-

tient is the criterion for separating the preventive medicine codes, 99385 through 99397.

1-3. IMPLEMENTING THE ICD-9/CPT CODING SYSTEM.

a. The HCFA serves as the checkbook for Americans receiving care under the Medicare program. Office practices have changed as HCFA altered the rules for obtaining reimbursement from the HCFA checkbook. Prior to the 1980's, medical office practices completed a preprinted superbill which permitted a written description of the diagnosis and accepted a checkmark to indicate the services or procedures performed during the visit. The office kept one part of the Superbill for its records. Medicare enrollees paid the physician and used the second part as a receipt. Enrollees submitted the third part to the medicare carrier for payment. Office practice revenue depended on the number of office visits, each of which were reimbursed on the basis of the provider's Uniform, Customary, or Regular fee.

b. Superbills disappeared in 1988 when Congress passed the Medicare Catastrophic Coverage Act, which required the diagnosis, coded in ICD-9CM, to match the services provided, coded as CPT, or level 1 HCPCS. Practices entered the codes on the Universal Health Claims forms, identified as the HCFA-1500 form, on lines 21 and 24d, respectively. Coding was now a requirement for practices to receive reimbursement, but total reimbursement still depended on the count of visits.

c. The second step in enforcing the use of ICD-9CM/CPT codes occurred in 1992, when HCFA began a 5-year phase in of the Medicare Fee Schedule (MFS) which associated Resource Based Relative Value Units (RBRVU) for each CPT code that HCFA reimbursed. Implementation of the MFS based reimbursements on the RBRVU of the services provided, not on the number of office visits. For example, a new-patient, problem-focused visit, E/M code 99201, represented 0.38 physician RBRVU, while an established patient detailed visit, E/M code 99213, represented 0.55 physician RBRVU. Added to these physician RBRVU are practice expense and malpractice RBRVU, to account for differences in practice expense and legal exposure. The total RBRVU for a procedure is the weighted average of 54% physician work, 41% practice expense and 5% malpractice cost. Multiplication of the total RBRVUs by an annually adjusted conversion factor yielded the total reimbursement to the practice. Table 1-1 shows how the MFS varies with location for two E/M codes. The important issue is that the MFS forced civilian practices to use CPT codes to record services rather than just count the number of visits.

CPT is a systematic listing and coding for procedures performed.

TABLE 1-1. MFS, 1996, for two outpatient E/M codes for different locations. This table illustrates the effect of practice location. Two E/M codes, each with similar physician work RVU, have different MFS depending on the RVU assigned to practice expense and malpractice cost for a specific location.

E/M Code	Richmond, VA	Buffalo, NY
99203	\$54.97	\$30.86
99211	\$32.84	\$36.71
E/M Code	Rochester, NY	Manhattan, NY
99203	\$60.37	\$72.53
00313	\$33.46	\$21.26

d. The basic model for reimbursement is a patient visit to the provider with CPT describing “what” the provider did and ICD-9CM describing “why” the doctor provided the service or procedure. Emphasis is on services, while workload of the ancillary staff to support that visit is a secondary issue. Physicians receive reimbursement based on the complexity of the services provided to the patient as outlined in the MFS. Since the introduction of the Medicare program, the number of CPT codes available for reimbursement has grown from 2,000 codes in 1965 to 7,000 codes in 1997. The expansion of the codes parallels the growth of Medicare expenditures (see Table 1-2).

TABLE 1-2. Growth of health care from 1965 to 1996 expressed in terms of the number of CPT codes, Medicare expenditure, and total health care expenditure. (Medicare expenditures and Total Health Care expenditures from Ginzburg, E, “The changing US Health Care Agenda” JAMA 279,7, 501 - 504, Feb 18, 1998).

	1965	1996
Number of CPT Codes	2,000	7,000
Medicare Expenditure	\$10 billion	\$160 billion
Total Health Care Expenditure	\$20 billion	\$300 billion

e. Because total reimbursement is tied to ICD-9CM/CPT code selection, medical practices and hospitals have a financial incentive to overcode, that is, to use CPT codes that represent more RBRVU than the services actually provided. An HCFA intra-agency audit of 1996 Medicare payments estimated \$23 billion in questionable reimbursement, 22% accounted for by physicians services. To put teeth into HCFA’s medical record audits, the Federal False Claims Act of the Health Insurance Portability and Accountability Act of 1996 stated that submitting a claim for an item or service based on incorrect coding can result in a civil monetary penalty. This is no idle threat. Recently the group practice for the University of Virginia Medical School returned over \$8.6 million to HCFA because of an audit that revealed coding irregularities. Accuracy of coding and compliance with the HCFA coding rules are now a major issues for private practices.

1-4. THE HCFA – 1500 FORM AND THE BILLING CYCLE.

a. The universal medical insurance claims form is HCFA-1500 form (see following page). The HCFA developed this form as the method for submitting payment for Medicare claims. Because of its extensive use for Medicare and Medicaid programs, most other insurers also require physicians to submit this form to receive reimbursement. Military clinics will recognize this form as the OWCP-1500 used by civilian physicians when submitting claims for medical services provided to civilian workers compensated under the Federal Employees Compensation Act (FECA). Military providers will not use the HCFA-1500 form, but staff in the Third Party Collections office are familiar with its use.

b. Blocks 21 and 24 show the relation between the diagnosis and the services provided. Note that at block 24D the provider must correlate the service provided with the diagnosis. This is the match between the medical necessity for the services, the ICD-9 code, and the service provided, the CPT-4 code. The HCFA will deny a civilian physician’s claim for services if the diagnosis and service do not match. An obvious mismatch is the diagnosis of prostate hypertrophy (ICD-9 code 600), with the service provided as normal vaginal delivery (CPT code 59400). Both Medicare and private insurance carriers run computerized screening checks of the codes entered into these two blocks. Only those claims that pass these screenings, called clean claims, receive immediate payment.

**Form
HCFA-1500**

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

CARRIER

**Health Insurance
Claim Form**

*Military providers will
not use this form, but
they should be aware
of blocks 21 and 24.*

HEALTH INSURANCE CLAIM FORM																																																																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)																																																																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																											
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)																																																																																											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																	
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																																																																																											
SIGNED _____ DATE _____			PIN# _____			GRP# _____																																																																																											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

c. Most medical office systems installed in a private physician's office use an encounter form to accumulate patient demographic data, diagnosis, and procedure information. Some civilian encounter forms are similar to the Ambulatory Data System (ADS) encounter forms (please do not use the term "bubble sheet"). Most private practices employ a coder who checks the accuracy of the ICD-9 and CPT codes selected by the provider on the encounter form. The coder then enters the corrected codes

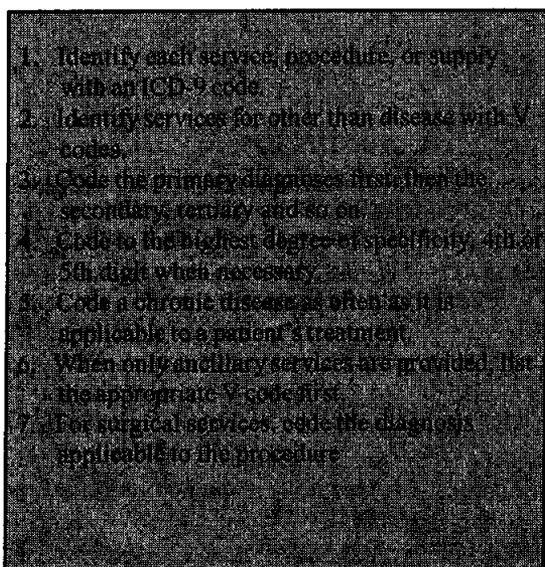
into the office system. At the end of the day the billing clerk either prints the HCFA-1500 for mailing to the designated insurance company or electronically transmits the HCFA 1500 to the Medicare carrier for the local area. While private physician providers, like their military counterpart, never actually see the HCFA-1500, the billing cycle ends only upon the accurate completion and acceptance of this form by the insurance carrier.

CHAPTER TWO: MEDICAL NECESSITY, ICD-9CM CODING FOR ACUTE CARE

2-1. INJURY AND ILLNESS CODING.

a. Workers may receive acute and chronic care for injuries and illnesses (I/I) at OEM practices. The rules for ICD-9 coding for OEM services are no different from those for the emergency room or primary care clinic. By following the HCFA guidelines (see Table 2-1), coders convert the worker's symptoms, signs, and complaints into an ICD-9 code, which establishes the medical necessity of the visit. The introductory section of all codes books presents these HCFA guidelines in more detail. A variety of educational seminars and reference texts are available to train clinic staff who may not be familiar with the use of the coding books and the selection of ICD codes. When coding for I/I at military OEM clinics, use the same codes and rules as those used by civilian coders. The only difference is that military clinics enter codes on the ADS encounter form, while civilian clinics will enter the same codes on the HCFA-1500 form.

TABLE 2-1: Procedures established by HCFA to determine the appropriate ICD-9 code for entry onto blocks 21 and 24D of the HCFA-1500 form. (These coding procedures are described in all ICD-9 manuals sold to private practices.)



1. Identify each service, procedure, or supply with an ICD-9 code.
2. Identify services for other than disease with V codes.
3. Code the primary diagnosis first, then the secondary, tertiary, and so on.
4. Code to the highest degree of specificity, 4th or 5th digit when necessary.
5. Code a chronic disease as often as it is applicable to a patient's treatment.
6. When only ancillary services are provided, list the appropriate V code first.
7. For surgical services, code the diagnosis applicable to the procedure.

b. Two coding considerations are important for the OEM practice, which may not be apparent when coding for family practice or emergency room visits. The first is that the OEM practice uses only the ICD-9 codes, which prompted the workers' visits regardless of other chronic conditions that may be present. This situation arises when an employee with chronic conditions presents for acute care. As an example, consider an employee under treatment for hypertension who sustains a laceration to the finger. The reason for the visit to the OEM clinic is due to a laceration (coded as 883.00 under category Open Wound), not the hypertension. The civilian coder will place 883.00 as the first code in item 21 of the HCFA-1500 (OWCP-1500). The military coder checks the preprinted box for 883.00 on the ADS encounter form, or if not preprinted enters 883.00 on the back of the encounter form as the primary diagnosis. Like the civilian provider, the military clinic should avoid coding for a nonessential diagnosis, such as the hypertension. The laceration, not the hypertension, is the reason for the care provided to this employee.

c. The tabular list of diseases, Volume 1 of the ICD-9CM book, ranges from 001 for cholera to 999.9 for unspecified complication of medical care. For the novice, finding the appropriate code for an I/I can be daunting. The first step is to follow the coding procedures outlined in Table 2-1. Always start with the alphabetic index, Volume 2, using the diagnostic term for the I/I. Associated with this term will be a three-digit number or number range. Enter Volume 2 using this number. Select the highest order number, up to five digits, that matches the employee's specific I/I. Do not select the code given from the alphabetic index since the tabular list, Volume 2, usually has more specific diagnoses, each numbered beyond the decimal place of the three-digit code.

d. Suppose the employee has no specific diagnosis, but merely signs and symptoms. In this case refer to Section 16 of the ICD-9CM book titled, "Signs, Symptoms, and Ill Defined Conditions." This section contains codes 780, General Symptoms, to 799, Ill Defined Symptoms. Use of these codes is as acceptable as are numeric codes for specific diagnosis. From the billing prospective the important issue is why the employee sought care in the OEM clinic, not the diagnostic acumen of the provider.

Coding for acute injuries and illness is the same for Occupational Health Clinics as it is for Primary Care Clinics.

e. In the industrial environment some injuries occur more frequently than others. In 1996 Allen and Blumberg recorded the frequency of diagnosis seen at the staff sick call which serviced the Naval Hospital Portsmouth and Norfolk Naval Shipyard. Appendix A lists the common diagnoses seen during a 1-year period. While the mix of patients will certainly vary at other military OEM clinics, a coder may wish to use Appendix A as a quick reference for commonly seen diagnoses. The codes used in Appendix A are selected directly from the ICD-9CM list. Appendix A lists less than 200 codes, which should cover the needs of most OEM clinics.

f. Other lists of common diagnoses coded in ICD-9CM are also available. For the Family Practice, Appendix B lists diagnoses taken from a popular medical practice text. Sentinel events represent failure in disease prevention. Diseases that represent sentinel events should be rare. Appendix C lists the ICD-9CM codes for sentinel events. The diseases appearing on Appendix C should not be frequent enough to place on the ADS encounter form. This appendix is for information only.

2-2. UNIQUE CODES, The E CODES.

a. In the industrial setting, I/I usually arise in the context of an industrial accident. The ICD-9 classification contains E codes which explain the cause of the injury. For the OEM practice the place of occurrence is usually at the industrial location, so E codes describe the specific nature of the industrial accident. E codes are NEVER the primary code; rather, they are an addition to a code from the main chapters of the ICD-9 book. Enter the E code on item 21 as a secondary diagnosis following the primary numeric code.

b. The ICD-9CM codes book contains a section on E codes usually at the end of the alphabetic list, Volume 2. Like the numeric codes, E codes have specific sections and a hierarchical organization. Table 2-2 outlines those E codes sections that are most applicable to the practice of OEM. E codes describe accidents that arise in the industrial environment as a cause of injury. For example, overexposure to industrial chemicals, pesticides, and motor vehicle exhaust gases are in sections E860 through E869. Motor vehicle accidents are in sections E810 to E819. Sections not listed in Table 2-2 are for situations generally not encountered in the typical OEM practice, such as an injury that arises from medicinal error, suicide, and acts of war.

Table 2-2. Selected E codes and their definition as applicable to the OEM practice.

Definition	E code
Hypodermic needle as cause of accident	E920.5
Overexertion and strenuous movements from pulling, lifting, and pushing	E927
Exposure to noise, noise pollution, and sound waves	E928.1
Motor vehicle accidents involving collision on the highway with injury to the:	
driver of the vehicle	E814.0
passenger	E814.1
pedestrian	E814.7
Motor vehicle accident involving collision with other motor vehicle with injury to the:	
driver	E812.0
passenger	E812.1
Accidental poisoning by insecticides of the organophosphorus compounds	E863.1
Accidental poisoning caused by motor vehicle exhaust	E862.2
Accidental poisoning by unspecified solids and liquids	
lead and its compounds and fumes	E866.0
mercury	E866.1
antimony	E866.2
arsenic	E866.3
other metals and their compounds	E866.4
Falls from ladders or scaffolding	E881.0

2-3. SCENARIOS FOR I/I CODING

Listed below are four scenarios illustrating the use of ICD-9CM numeric codes to describe the I/I. Where appropriate, the scenario also presents the E code. Coders may improve their proficiency in coding entering E codes to support the primary diagrams. At this time ADS coding does not accommodate E codes even when these codes are entered on the encounter form.

A drill press operator lacerates two fingers while operating the press. The injury does not result in tendon damage.

Primary Dx: 883.0
Secondary Dx: E919.3

Discussion: Code 883.0 is for an open wound of the fingers without complications. E919.3 represents the power press as the cause of the injury.

Scenario 2-1:

An employee is being evaluated by his primary care provider for possible hypertension. He regularly stops by the clinic for blood pressure checks.

Primary Dx: 796.2
Secondary Dx: None

Discussion: At this time the need for the visit is to evaluate possible elevated blood pressure, code 796.2, rather than treat a patient with an established diagnosis of hypertension, code 401.9. For the later diagnosis, category 401 describes hypertension with addition codes, 402 - 405 for the complications of this disease.

Scenario 2-2:

A construction foreman working in an enclosed space next to an operating gasoline engine collapses. Upon his presentation to the OEM clinic, the foreman is alert, but his carboxyhemoglobin level is elevated.

Primary Dx: 780.2
Secondary Dx: E868.2

Discussion: The OEM practice used the symptomatic code for syncope, 780.2, and specified motor vehicle exhaust, E868.2, as the cause of injury. Subsequent testing and evaluation may convert the symptomatic diagnosis to specific diagnosis of 986, toxic effects of carbon monoxide. This scenario highlights the 780 series of codes used to describe symptoms. These codes are most appropriate for provisional diagnoses.

Scenario 2-3:

CHAPTER THREE: MEDICAL NECESSITY, ICD-9 CODING FOR SURVEILLANCE EXAMS

3-1. UNIQUE VISITS TO THE OEM PRACTICE.

a. The first step in obtaining reimbursement from a third party payer is to establish the reason for the medical service. For injury and illness, discussed in the previous chapter, the patient has symptoms or injury. The coder uses the numeric part of the ICD classification to describe these symptoms, illnesses or injuries. While primary and emergency care are well described by these numeric codes, OEM services frequently involve care to workers without specific symptoms or complaints. Consider a medical surveillance or job certification exam in which the employee seeks care as a preventive measure or as a requirement for continued employment. The numeric codes which describe illness and injury are not sufficient to describe the medical necessity for a visit by an apparently healthy worker.

b. For the purposes of coding, six different visit types are unique to OEM practices. These are exams for Return to Work (RTW), Disability Evaluations (DE), occupational medicine consults, certifications, driver's license, and surveillance. While the Fitness For Duty (FFD) exam is another type of visit, from a coding perspective this exam is similar to the DE. Table 3-1 describes each of these types of visits and provides examples from an OEM practice. Grouping visits to the OEM practice into these six categories permits easier selection of the appropriate ICD code. The central theme in all these visits is that the worker seeks OEM service for a purpose other than to relieve symptoms or acute illness. For visit types not associated with a specific medical complaint, the ICD classification provides the V codes to describe medical necessity.

3-2. V CODE CLASSIFICATION

a. V codes are a separate section of Volume 1, tabular list in the ICD-9 Manual. Their purpose is to provide a classification for those situations when a person seeks medical care for reasons other than injury or illness. V codes always begin with a "V" followed by a number. Like the numeric codes, specific coding may require a third and even a fourth digit. Some V codes, such as those for the V15 services, may not serve as primary diagnoses. All V codes may be used as secondary diagnoses. This coding situation arises when an employee presents with a stable medical condition but requests services described by V codes. Sections within the V code classification describe health care services for com-

TABLE 3-1. Specific visit types that are unique to occupational health (OH). Listed below are six unique OH visit types, each with a definition and example.

Visit type	Definition	Example
Return To Work	Considerations are the current health status of the work and the safety sensitivity of the worker's job. Other concerns involve the previous health care of the worker and extent of recovery gained by this care.	1. Competency following rehabilitation for substance and alcohol abuse 2. Return to work evaluation following an injury or illness
Disability Evaluation or Fitness For Duty	An examination oriented towards defining the extent of the examinee's disability. Outcome of this exam is a rating or opinion which is the extent of the disability compared to a whole or fully functional person.	Disability evaluation for purposes of insurance coverage or for continuation of employment
Certification	As a result of this visit the employee has a doctor's certificate to continue a specific job or wear specific personal protective equipment. To obtain this certificate the employee must not have any disqualifying medical conditions. In some circumstances the FFD is a type of certification exam.	1. Respirator certification 2. Federal Aviation Administration physical 3. Food service worker exam
Driver's License Exam	A specific type of certification based on Department of Transportation requirements for motor vehicle operators or operators of heavy equipment.	1. Motor vehicle operator, all classes 2. Crane operator
Surveillance Exam	Identifies the earliest reversible biologic effects so that the exposure can be reduced or eliminated before the employee sustains irreversible damage.	1. Noise 2. Asbestos 3. Lead 4. Hazardous drug
Consult to OEM Practice	The OEM practice receives consults to address concerns of otherwise healthy workers or non-employees. A primary reason for consults is to address concerns about possible overexposure.	1. Evaluate the possibility of an adverse reproductive outcome. 2. Group or individual counseling

municable disease, health hazards, reproductive and developmental circumstances, aftercare, and live-born infants.

b. The three V codes used as the primary diagnoses for three of the unique visit types are V70.5, V70.3, and V68.0. For surveillance exams use code V70.5. This V code reflects health exams for defined populations. Examples of these populations are employees selected for pre-placement examination, firefighters, police, and workers in surveillance programs for specific hazards. For driver's license exams use V70.3, defined as exams for administrative purposes. When the physician issues a specific medical certification, such as a respiratory certification or certification as a food worker, use V68.0. Although V68.0 and V70.3 are V codes used as primary diagnosis, in the RTW and DE, the code serves as a secondary diagnosis.

c. For the OEM practice, three V codes describe the reason for the unique occupational health visits described in Table 3-1. Table 3-2 outlines the use of these three codes for each visit type.

(1) **V68.0** are encounters for administrative purposes such as the issuance of a medical certification, rating, or statement. Use this code as the primary diagnosis for an Occupational Safety and Health Administration (OSHA) mandated certification program, such as the Respiratory Protection Program, and as the secondary diagnosis for the RTW, which results in the issuance of a fitness for duty statement.

(2) **V70.3** is applicable for an examination required for issuance of a driver's license under Department of Transportation guidelines. Also use this code for issuance of military-specific motor vehicle operating permits, including crane operator exams. Use this code as the secondary diagnosis for a disability evaluation when the physician completes an impairment rating or other insurance certificate. For the DE, the primary diagnosis is the numeric code for the injury.

(3) **V70.5** is the code used for health exams of a defined population such as groups of workers in

surveillance programs. These are workers without specific disease who require periodic screening based on OSHA-mandated exposure levels for hazardous chemicals, vision standards, or noise level. To obtain detail on the nature of the surveillance exam, the coder may use specific V codes as secondary diagnoses, see Table 3-3. The V codes in this table are for secondary diagnosis only and MAY NOT SERVE as primary diagnoses. Four of the secondary diagnoses are the V15 category, which the ICD-9CM code book titles as "Other Personal History Presenting Hazards to Health." Only radiation, (V15.3), asbestos (V15.84), hazardous body fluids (V15.85) and lead (V15.86) reflect specific hazards. For a surveillance exam, codes V72.0 and 72.1, along with the V15 codes, must be the secondary diagnoses with V70.5 as the primary code.

d. Occupational audiologists should be aware of code **V80.3**, which is part of the V80 category for Specialty Screening for neurological, eye, and ear diseases. The code **V80.3** reflects a health status exam for ear disease. General hearing exams remain as **V72.1** so routine surveillance for employees in the Hearing Conservation Program should use this code. Occupational Audiologists will use **V80.3** to reflect a visit for any special study.

Table 3-2. Recommended V codes for visits types unique to OH. This table illustrates the suggested primary and secondary V Codes for each visit type.

Visit Type	Primary Code(s)	Secondary Code(s)	Comments or Services Provided
Return To Work	Provisional symptoms or specific diagnosis	V68.0	OEM staff may provide a wide range of services as needed to make a decision for RTW. Use the Evaluation and Management codes, see Chapter 4
Disability Evaluation	Specific diagnosis or FFD	V70.3	Two primary services are provided, see Table 3-1.
Certification	V68.0	None	Healthy worker
Driver's License Exam	V70.3	None	Healthy worker
Surveillance	V70.5	Table 3-3	Specific surveillance programs
Consult	Specific diagnosis	V70.5	Use V70.5 if no numeric code is appropriate for specific diagnosis.

e. Two other V codes are sometimes applicable for RTW or consultation exams. Code V62.2 is available as a secondary code when dissatisfaction with employment is the reason for the visit. Workers and non-employees may visit the OEM practice because of their concerns about the reproductive consequences of a potential exposure. Use V26.4 to describe this visit.

f. The V code classification has codes describing exams for specific purposes. Use these codes as secondary diagnoses in order to describe the purpose of the surveillance exam. Table 3-3 lists secondary codes that may describe types of surveillance exams. For example, an exam for the Hearing Conservation Program would receive codes V70.5 to reflect the primary diagnosis as a surveillance exam, with code V72.1 to indicate the emphasis on hearing conservation. Use as many secondary codes as applicable.

Table 3-4. Examples of provisional symptoms which may prompt a fitness for duty evaluation.

Provisional symptoms as:	
Drunkenness	903.02
Hangover	903.02
Sleeping	780.54
Chest pain	785.51
Mildew/dread	780.7
Specific diagnoses as:	
Codeine abuse	304.23
Amphetamine	304.01
Personality disorder with anxiety	312.73

Table 3-3. V codes used as secondary diagnoses to the primary code of V70.5 for medical surveillance. The table shows the V codes, title and examples of worker populations likely to be in the surveillance program.

V Code	Title of Examination	Worker Population (examples)
V72.0	Eye and vision	Sight conservation
V72.1	Ears/hearing	Hearing conservation
V73.3	Radiation	Radiation workers
V73.4	Asbestos	Asbestom workers
V73.5	Hazardous body fluids	Health care workers
V73.6	Lead	Automobile workers
V73.89	Other programs	Other programs for stressors

The V codes in Table 3-3 are for secondary diagnosis only and MAY NOT SERVE as primary diagnoses.

g. Both the RTW and DE require a numeric ICD code as the primary diagnosis. For the RTW exam the employee may present with symptoms or a provisional diagnosis. Table 3-4 lists examples of both common or provisional diagnoses and specific diagnoses that may serve as the primary code. The OEM physician determines this employee's fitness to return to work. Use as the secondary code V68.0. For the DE, the employee presents with a specific diagnosis for which an insurance company or the Federal Employee Compensation Act (FECA) administrator has a specific insurance certification or rating percentage. For this visit type use as the secondary code V70.3.

h. Many visits to the OEM clinic are for both certification and surveillance exams. For these combined exams use V68.0 as the primary exam to reflect the issuance of a medical certificate and code V70.5 as the secondary code to reflect the population-based exam. The coder may then use additional secondary codes, as listed in Table 3-3, to specify the exact nature of the surveillance exam. Employees whose examination includes the issuance of a medical certificate for a motor vehicle license should receive the code V70.3 as the primary diagnosis.

3-3. SCENARIOS USING ICD-9 CODES.

Scenario 3-1

The middle-aged assembly line worker is returning to the job after a 4-week recuperation following an anterior myocardial infarction. Although the recovery was uneventful, the company policy requires a medical evaluation prior to returning the employee to work on the assembly line.

Primary Dx: 410.01, Acute anterolateral myocardial infarction
Secondary Dx: V68.0 Return To Work exam

Scenario 3-2

When reporting for his shift this intercity bus driver has a brief conversation with his supervisor. The smell of alcohol prompts the supervisor to request a fitness for duty evaluation. The physician finds the driver unfit for duty because of acute intoxication.

Primary Dx: 303.02 Drunkenness, acute
Secondary Dx: V68.0 DE/FFD exam

Scenario 3-3

The OEM physician has performed a DE on a material-handling worker who suffered herniation of the L4 - L5 intervertebral disk several years ago. Laminectomy failed to relieve sciatic pain and the patient now has the diagnosis of post laminectomy syndrome. The physician's medical evaluation finds disability from the post laminectomy syndrome which the employee's provider codes as 722.83.

Primary Dx: 722.83 Post laminectomy syndrome, lumbar region
Secondary Dx: V70.3 Disability evaluation rating

Scenario 3-4

A health care worker requests medical clearance for use of a respirator as part of the hospital's respiratory protection program

Primary Dx: V68.0 Medical certification
Secondary Dx: None

Scenario 3-5

A truck driver received a medical exam, based on the Department of Transportation standards, that qualifies him for his class 2 operator's permit. During the exam the physician noted several minor findings that were not disqualifying

Primary Dx: V70.3 Drivers's License exam
Secondary Dx: Code for findings if desired

Scenario 3-6

A retired asbestos worker who reports no symptoms receives an asbestos medical surveillance exam as required by his company

Primary Dx: V70.5 Surveillance Exam
Secondary Dx: V15.84 Asbestos type exam

Scenario 3-7

A worker enters the clinic visibly upset after a dispute with his co-workers. Blood pressure is initially elevated but returns to normal as the patient "cools down." He is referred to the Human Relations Department and released.

Primary Dx: V62.2 Psychosocial maladjustment
Secondary Dx: 796.2 Elevated blood pressure

The code V62.2 is for psychosocial circumstances of maladjustment. Another possible code is V62..81 to reflect interpersonal problems, not elsewhere classified. Note that the elevated blood pressure, code 796.2, is the secondary diagnosis