Coding and Reimbursement Information Every Physician Should Hear

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Disclaimer

• This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.
Complex Patient

• What does it mean to you?
  – Sick patient
    • Acutely ill
    • Multiple chronic illnesses

• How do you communicate this to the insurance company?

• Why should you care as long as I get paid?
SS Act - Medical Necessity

• Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
  
  — (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,
Medicare Carrier’s Manuel
Chapter 12: Sec 30.6.1

• “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

• “The volume of documentation should not be the primary influence upon which a specific level of service is billed.”
Medical Necessity

DO NOT ASSUME

• Just because a treating provider
  – Orders,
  – Prescribes,
  – Approves, and/or
  – Directs Care
• ....that the service will be considered medically necessary

DO NOT ASSUME

• Just because you got paid you did it correctly
  – Audits
    • RAC
    • CERT
    • OIG
• ... they can still take back the money and extrapolate the error
Medicare’s Definition of Medical Necessity

• "Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are
  – provided for the diagnosis, direct care, and treatment of a medical condition
  – meet the standards of good medical practice in the local area
  – aren’t mainly for the convenience of the patient or doctor.”
TELL THE STORY
The “Complex” Patient

Chief complaint?
Why are they here today?

• Chief complaint – why are they there today?
  – “I’m OK”
  – “Feeling fine”
  – “No problems”
  – “About the same”
  – “Need refills”

Management of Chronic Illnesses

• List illnesses and their status since the last visit
  – Hypertension
    • Well controlled
  – Arthritis
    • Stable
  – Diabetes
    • Poorly controlled
The “Complex” Patient

• Tell 4 things about their illness/disease
  – How has your \((chronic\ disease)\) been?
  – Have you had any \((symptoms)\) ?
  – How bad was it?
  – What made it better?
  – How long has it been since your last episode?

• HPI
The “Complex” Patient

• What other diagnoses are affecting your decision making?
  – Is the patient’s diabetes affecting your antibiotic choice?
  – Is the patient’s hypertensive medication contributing to their gout?
  – Will giving them a Cox-2 inhibitor putting them at a higher risk for cardiac conditions?
DIAGNOSIS CODING

• Tells the story
  – Indicate the status of chronic conditions
  – Indicate severity or improvement of chronic condition
  – Indicate episodes of “flare ups”, “out of control”, “unchanged”
  – Indicate cause/effect or other relationships
DIAGNOSIS CODING
What Can Staff Do?

• Body Mass Index (BMI)
  – Based on medical record documentation from clinicians who are not the patient’s provider
  – BMI is a height/weight calculation
  – Overweight, obesity, morbid obesity must be documented in medical record by the clinician

WHAT HAPPENS TO YOUR DIAGNOSIS INFORMATION?

• Diagnosis code is assigned by physician
  – Problems?
• Diagnosis code is assigned by staff
  – Problems?

• Is it the correct code?
  – Severity
  – Cause/effect
  – Guidelines to follow
WHAT HAPPENS TO YOUR DIAGNOSIS INFORMATION?

• Does your staff “skip” diagnoses because they can’t locate a code in their ICD-9 book?
  – Not enough information
  – Don’t understand anatomy or disease process

• Make sure your staff isn’t putting you in jeopardy on audit with their coding/billing practices
Concurrent Care

• “...where more than one physician renders services more extensive than consultative services during a period of time."

• Items to watch
  – Use diagnosis code specific to care provided
  – Provider specialty and diagnosis relationship
  – Verify specialty with carriers

  – MCM Chapter 15: 30E
Concurrent Care
Concurrent Care

• Type II Diabetes, uncontrolled
  – Internist
• Pneumonia
  – Pulmonary
• CHF
  – Cardiology

• Pneumonia
  – Internist
• CHF
  – Pulmonary
• Diabetes
  – Cardiology
MODIFIER 25 & 59

Modifier 25
• The patient’s condition requires a separate identifiable E&M service that was above and beyond the other service or above and beyond the usual preoperative and postoperative care associated with the procedure performed.

Modifier 59
• A circumstance which indicates a procedure or service was distinct or independent from other non-E/M services performed on the same day. Used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under circumstances
MODIFIER 59

- To indicate a procedure or service was distinct or independent from other non-E/M services performed on the same day.
- Used to identify procedures or services, not normally reported together but are appropriate under circumstances.
MODIFIER 59

• Documentation must support a:
  – Different session
  – Different procedure or surgery
  – Different site or organ system
  – Separate incision or excision
  – Separate lesion
  – Separate injury
Modifier -59 : OIG findings

• 40% error rate!

• Services were not distinct (53%)
• Service not adequately documented (25%)
• Documentation unclear or no documentation provided (28%)

• http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf
Modifier 25 OIG

- 35% of claims did not meet requirements needed
  - E/M services were not significant, separately identifiable,
    - above and beyond the usual preoperative and postoperative care associated with the procedure;
    - or
    - failed to meet basic Medicare documentation requirements
- Significant numbers of claims had a modifier 25 appended to an E&M when no other service was performed
Modifier 25 OIG

• August 2011, settlement for a practice in Pennsylvania for erroneously submitting claims
  – False Claims Act

• Paid $1.3million to resolve allegations over modifier 25 use
  – Claims 2001-2006
    • Corrective action was taken in 2005
  – Settlement was seen as best result because practice of using modifier 25 was discontinued
PHYSICIANS QUALITY REPORTING INITIATIVE - PQRS SYSTEM - PQRS
PQRS – Factors in Selection Process of Measures

• Clinical conditions usually treated
• Types of care typically provided
  – e.g. Preventive, chronic, acute
• Settings where care is usually delivered
  – e.g. Office, ED, Surgical suite
• Quality improvement goals for 2011
Asthma Assessment

Coding Specifications
Codes required to document patient has asthma and a visit occurred:

A list item ICD-9-CM diagnosis code for asthma and a CPT code are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

Asthma line item ICD-9-CM diagnosis codes
- 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92 (asthma)

AND

CPT codes
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

Quality codes for this measure:

CPT II Code descriptors
(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1005F**: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

- **CPT II 1005F–8P**: Asthma symptoms not evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire), reason not otherwise specified
# Asthma Assessment

## PQRI Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender (Male, Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td></td>
<td>Date of Service</td>
<td></td>
</tr>
</tbody>
</table>

## Clinical Information

### Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 5 through 40 on date of encounter.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has a line item diagnosis of asthma.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is a CPT Code for this visit.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

### Step 2  Does patient meet the measure?

<table>
<thead>
<tr>
<th>Asthma Symptom Frequency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for the above, report 1005F–8P (Asthma symptoms not evaluated [includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire], reason not otherwise specified.)

## Billing Information

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify date of birth on claim form.</td>
<td>1005F</td>
</tr>
<tr>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.</td>
<td></td>
</tr>
</tbody>
</table>
Physician Quality Reporting Initiative

- Reporting Period
  - January 1, 2011 to December 31, 2011 or
  - July 1, 2011 to December 31, 2011

- Incentive payment
  - 1% Medicare payments made to EP or Group
    - 2% for 2010

- Reduced reporting sample for claims based reporting of individual measures to 50% from 80%

- Creates a new Group Practice Reporting Option (GPRO) that would allow group practices with fewer than 200 EPs to participate
PQRS Changes in 2011

• 2011-2014 additional 0.5% incentive payment
  – Provide data on measures through an Maintenance of Certification Program (MOCP)
    • Operated by a specialty body of American Board of Medical Specialties (ABMS)
    • Additional criteria identified
    • 12 month reporting period
PQRS PROPOSED CHANGES 2012

• Consolidate to create one group reporting option defined as a group of 25 or more physicians

• Introduce 10 new measures groups
  – Cardiovascular Prevention     - COPD
  – Inflammatory bowel disease    - Sleep apnea
  – Epilepsy                     - Dementia
  – Parkinson’s                  - Radiology
  – Elevated blood pressure      - Cataracts
PQRI Reporting Mechanism

• Through Claims or Qualified Registry
  – Individual quality measures
  – Measures groups

• Qualified Registry

• Qualified EHR product
PQRI
Incentive vs Dis-incentive

- 2% Incentive
  - 2009-2010
- 1% Incentive
  - 2011
- 0.5% Incentive
  - 2012-2014

- 1.5% Dis-incentive
  - 2015 if in PQRI
- 2.0% Dis-incentive
  - 2016+ if not PQRI

ICN# 903691 (September 2010)
# E-Prescribing

## Incentive vs Dis-incentive

**Satisfactorily Participate**

- **2% Incentive**
  - 2009-2010
- **1% Incentive**
  - 2011-2012*
- **0.5% Incentive**
  - 2013

**Non-participation**

- * 2011–no hardship
- **2012**
  - 1.0% Dis-incentive **
- **2013**
  - 1.5% Dis-incentive
- **2014**
  - 2.0% Dis-incentive

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ICN# 903691 (September 2010)
Offsetting Revenue Losses and Gains
Relative Value Unit

- Malpractice Expense
- Practice Expense
- Physician Work

- Total RVU x multiplier = reimbursement

- Medicare 2009 = $36.06
- Medicare 2010 = $28.39  --  $36.0846
- Medicare 2011 = $33.9764
- Medicare 2012 Proposed $23.9635 ↓ 29.5%
Components of Medicare RVU

THREE COMPONENTS

• Work RVU (wRVU) ≈ 52%
  – Relative time, effort, and skill needed by a provider in the provision of a procedure

• Practice Expense RVU (peRVU) ≈ 44%
  – Costs associated with maintaining a practice, such as rent, equipment, supplies and staff

• Malpractice Expense RVU (mRVU) ≈ 4%
  – Professional liability insurance
## Relative Value Units

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Work</th>
<th>Practice Expense</th>
<th>Malpractice</th>
<th>TOTAL RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>99213</td>
<td>0.97</td>
<td>0.80</td>
<td>0.05</td>
<td>1.82</td>
</tr>
<tr>
<td>Lesion Removal</td>
<td>11100</td>
<td>0.81</td>
<td>1.75</td>
<td>0.08</td>
<td>2.64</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>45378</td>
<td>3.69</td>
<td>1.82</td>
<td>0.42</td>
<td>5.93</td>
</tr>
<tr>
<td>Total Hip Replacement</td>
<td>27130</td>
<td>21.79</td>
<td>13.26</td>
<td>3.08</td>
<td>38.13</td>
</tr>
<tr>
<td>EKG</td>
<td>93000</td>
<td>0.17</td>
<td>0.36</td>
<td>0.02</td>
<td>0.55</td>
</tr>
<tr>
<td>EKG – only interpretation</td>
<td>93005</td>
<td>0.00</td>
<td>0.29</td>
<td>0.01</td>
<td>0.30</td>
</tr>
</tbody>
</table>
CPT - Time

• When counseling and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or unit/floor time in the hospital or nursing facility) time may be considered the key or controlling factor to qualify for a particular level of E/M service.”

**Medical Necessity**
“Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment options)
- Risk factor reduction
- Patient and family education”
MCM Chapter 12 – Section 30.6.1

• “The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.”
Prolonged Physician Services Office

- + 99354 – Prolonged physician service office or other outpatient setting: first hour
- + 99355 - each additional 30 minutes
  
  - Face to Face time (CPT & CMS)
  - List separately in addition to code for office or other outpatient Evaluation and Management service
  - Threshold for use of code 30 minutes
Prolonged Physician Services Hospital

- + 99356 – Prolonged physician service inpatient setting: first hour: first hour
- + 99357 - each additional 30 minutes

  – Face to Face time (CMS)
  – Unit Floor (CPT)
  – List separately in addition to code for office or other outpatient Evaluation and Management service
  – Threshold for use of code 30 minutes
Prolonged Service
MCM Chapter 12:Sec 30:15.1 e

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
</tbody>
</table>
Documentation Requirements

• MCM Chapter 12:Sec 30:6:1D

• Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed.

• The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions.

• The start and end times of the visit shall be documented in the medical record along with the date of service.
# Time Based Coding for Physician Services

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>TYPICAL TIME</th>
<th>THRESHOLD TO BILL PROLONGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office New Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>75</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>Office Established Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>TYPICAL TIME</th>
<th>THRESHOLD TO BILL PROLONGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Initial Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99221</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>99222</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>99223</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99231</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>99232</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>99233</td>
<td>35</td>
<td>65</td>
</tr>
</tbody>
</table>
Prolonged Care

- Code selected based on requirements of elements of E&M visit
  - History, Exam, MDM
- Additional time spent face to face beyond published time for code
  - Minimum 30 minutes beyond
- E&M code billed and also prolonged care code

Counseling and Coordination of Care

- More than 50% of face to face time spent in discussions with patient
- E&M Code selected based on total time of visit
- Documentation total time and % of time spent C&C
- May have elements of E&M in documentation
45 Minute E&M Service

• If the dominate service has traditional elements of History, Exam and Medical Decision making.
  – 99213 (1.82) + prolonged service (2.69) = 4.51 RVU

• Bill If the dominant service is counseling and time is the basis of the code selection
  – 99215
  – TOTAL 3.68 RVU

• Based on Documentation
80 Minute Service

• If the dominate service has traditional elements of History, Exam and Medical Decision making
  – 99222 (3.58) + prolonged care (2.38) = 5.86 RVU
    • Published time 50 minutes
CRITICAL CARE TIME

2 Part Form for chart note

• Total Time*
• Documentation of “critical diagnosis”
• Documentation of procedures*
  – Time for each
• Charting time counts
SERVICES PERFORMED BUT FORGOTTEN
Smoking Cessation

- **99406** - Smoking and tobacco use cessation counseling visit;
  - intermediate, greater than 3 minutes up to 10 minutes
- **99407** - intensive, greater than 10 minutes

RVU 0.37 = $10.50
RVU 0.71 = $20.16
Patient Education and Training

• 98960 – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face to face with the patient each 30 minutes

• 98961 – 2-4 patients

• 98962 – 5-8 patients

RVU 0.66 = $18.74
RVU 0.32 = $9.08
RVU 0.24 = $6.81
Patient Education & Training

• Curriculum
  – “curriculum that is intended to promote wellness, prevention, and delay comorbidities”
    • CPT Assist
  – Curriculum...treatment of established illness(s)/disease(s) or to delay comorbidity(s)
    • CPT 2010
Patient Education & Training

• Qualifications of non-physician healthcare professional and the content of training
  – consistent with guidelines or standards established or recognized by
    • A physician society
    • Non-physician healthcare professional society/association
    • Other appropriate source
“NURSE VISIT” 99211

• Services must be reasonable and necessary for diagnosis or treatment of illness or injury

• Medicare requires documentation of both elements
  – Evaluation
  – Management

• 0.53 RVU = $15.05
“NURSE VISIT” 99211

• The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient.

• The management portion is substantiated when the record demonstrates an influence on patient care (ex.; medical decision making, patient education, etc.).
Prothrombine Time w/ 99211

- Examples that do NOT support use of 99211
  - Injection sheet and billing roster submitted for DOS
  - “The documentation shows the PT/INR test results, but no additional patient complaint or any action by nurse.
  - There is missing documentation to support the use of 99211. Examples are vital signs, weight, patient recent history, etc.
  - There is insufficient documentation to indicate the provider performed and E&M service
  - The documentation shows the reason for the encounter was exclusively for the purpose of venipuncture
  - There is no documentation of any face-to-face encounter.”
“Hospital Inpatient/Outpatient/Emergency Department Setting

• When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number.
• The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes).

• The split/shared E/M policy does not apply to consultation services, critical care services or procedures.
Inappropriate Documentation

• All were signed by the attending physician
  – I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written
  – Patient seen
  – Seen and examined
  – Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X.
  – No comment at all by the physician, or only a physician signature at the end of the note.
ICD-10

DO NOT BE AFRAID
Diabetes

- E08 – Diabetes due to underlying condition
- E09 – Drug or chemical induced diabetes mellitus
- E10 – Insulin dependent diabetes mellitus
- E11 – Non-insulin dependent diabetes mellitus
- E12 – Malnutrition related diabetes
- E13 – Other specified diabetes mellitus
Ischemic Heart Disease - I20 Angina Pectoris

• Use additional code to identify:
  – exposure to environmental tobacco smoke (Z58.7)
  – history of tobacco use (Z87.82)
  – occupational exposure to environmental tobacco smoke (Z57.31)
  – tobacco dependence (F17.-)
  – tobacco use (Z72.0)
• Excludes1:
  – angina pectoris with atherosclerotic heart disease of native coronary arteries (I25.1-)
  – atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris (I25.7-)
  – postinfarction angina (I23.7)
• I20.0 Unstable angina
  – Accelerated angina
  – Crescendo angina
  – De novo effort angina
  – Intermediate coronary syndrome
  – Preinfarction syndrome
  – Worsening effort angina
Crohn’s Disease

• ICD-9
  – 559.x – Regional enteritis
    • Large, small, combined, unspecified intestine
• ICD-10
  – Rubric contains 28 separate codes
    • Site
    • Complications of fistula
    • Obstruction
    • Bleeding
    • Abscess
    • Other
    • None
• K50.012 Crohn’s disease of small intestine with intestinal obstruction
<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>Malignant Primary</th>
<th>Malignant Secondary</th>
<th>Ca in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasm, neoplastic</td>
<td>C80.1</td>
<td>C79.9</td>
<td>D09.9</td>
<td>D36.9</td>
<td>D48.9</td>
<td>D49.9</td>
</tr>
<tr>
<td>abdomen, abdominal</td>
<td>C76.2</td>
<td>C79.8</td>
<td>D09.8</td>
<td>D36.7</td>
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<td>-</td>
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Accessory sinus—see Neoplasm, sinus
Insect Bite – ICD-9

• Insect Bite
  – Non-venomous
    • See injury, superficial, by site

• 919.4 Insect bite non-venomous, without mention of infection

• 919.5 Insect bite, non-venomous, infected
Insect Bite – ICD-10
Example

• A 32 y.o. hiker was bit by a venomous spider while hiking through the woods. He began experiencing muscle weakness and syncope and was rushed to the ED by a fellow hiker, where he was diagnosed with spider venom toxicity.
Example

T63.39 Toxic effect of venom of other spider
• T63.391 Toxic effect of venom of other spider, accidental (unintentional)
• T63.392 Toxic effect of venom of other spider, intentional self-harm
• T63.393 Toxic effect of venom of other spider, assault
• T63.394 Toxic effect of venom of other spider, undetermined
THANK YOU