

Autistic Disorder

Coding Tips & Billing Examples



Autistic Disorder

Autism is a brain disorder that limits a person's ability to communicate and relate to other people². Also known as autism spectrum disorder (ASD), the term "spectrum" reflects the wide variation in challenges and strengths possessed by each person¹. Some people can navigate their world, some have exceptional abilities, while others struggle to speak².

Symptoms of Autism

Signs of ASD tend to appear between 2 and 3 years of age and can include repeated motions and/or words, avoiding eye contact or physical touch, delays in learning to talk, and getting upset by minor changes². Additionally, some people with autism can experience physical symptoms such as constipation, sleep problems, poor coordination of muscles, and seizures². These signs, however, can also occur in children without ASD and at any age^{1,2}. It is important that caregivers talk with a healthcare provider to request a screening for autism.

Treatment of Autism

Treatment for ASD is dependent on screening results. A diagnosis of autism is not needed for people to begin receiving services related to developmental delays or learning challenges¹. Nonetheless treatments offered include behavior programs, individualized education program (IEP), medication, sensory processing, assistive technology, and diet².

Visit our website:

<https://www.homestatehealth.com/providers/tools-resources/coding-page.html>

Resources

1. Autism Speaks: What is Autism? (<https://www.autismspeaks.org/what-autism>)
2. WebMD: What is Autism? (<http://www.webmd.com/brain/autism/ss/slideshow-autism-overview>)
3. 2017 ICD-10-CM Expert for Physicians: The Complete Official Code Set, Optum360. 2016 Optum360, LLC



Autistic Disorder Coding Guidance

TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	F84.0 (Autistic disorder) ³
➤ Use additional code...	<p>... to identify any associated <u>medical condition</u> such as:</p> <ul style="list-style-type: none"> ○ Constipation ○ Sleep problems ○ Poor coordination of muscles ○ Seizures <p>...and intellectual disabilities such as <u>IQ</u>:</p> <ul style="list-style-type: none"> ○ Mild (IQ 50-69) F70 ○ Moderate (IQ 35-49) F71 ○ Severe (IQ 20-34) F72 ○ Profound (IQ under 20) F73 ○ Other intellectual disabilities F78 ○ Unspecified intellectual disabilities F79
➤ Avoid terms such as “history of”...	<p>... if patient is still being monitored for the condition.</p> <p> <u>Incorrect</u> wording: Patient has <u>history of</u> autism.</p> <p> <u>Correct</u> wording: Patient has autism and continues medication.</p>
➤ Documentation & Coding Tips	<p>The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention...</p> <ul style="list-style-type: none"> ○ if the patient is receiving therapy. ○ getting a refill on medication. ○ the status of the condition.

Resources

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Billing Sample #1



Primary Care Physician Documentation: Medical record SOAP format (condensed)

DOS: 05/01/2017
Gender: M **DOB:** XX/XX/2007 **Pulse:** 69 **Temp:** 98.8°F
Weight: 81.40lb **Height:** 4.4 **BMI:** 20.84

HPI: A 10 y.o. boy accompanied by mother. Reoccurring seizures monthly. He had a seizure in school yesterday in which he lost consciousness.

Problem List/History: Case Hx : Diagnosed with autism at ABC Hospital in 2015 after violent behavior reported with other children and adults during class.

Family Hx: Patient currently lives with his mother, his father is a marine.

Medical Hx : Diagnosed with autism two years ago and receives physical & occupational therapy.

Social Hx: Currently attends a Local Education Authority (LEA) Special School. He is in a small class with eleven other children, also in Key Stage Two. Paul has had an educational statement for his intellectual disability since he was five years old.

Medications Reviewed:
 Cymbalta, Flonase, Maxalt, Mucinex, Neurontin, ProAir inhaler, Remeron, Tessalon Perles, Latuda

Assessment and Plan:
Seizures – Increased Neurontin to 300mg daily
Memory loss NOS – Referral to Neuro specialist
Autism– Seeing counseling/therapy

Claim Diagnosis Codes & Rationale		
ICD-10-CM	Description	Medical Record Support
R56.9	Seizures (unspecified convulsions)	<ul style="list-style-type: none"> HPI: Provider documents patient had a seizure in school yesterday. Assessment & Plan: Provider listed Seizure and increased his Neurontin to 300 mg daily
F84.0	Autistic disorder	<ul style="list-style-type: none"> HPI: Provider documents patient was diagnosed with autism at ABC Hospital in 2015. Assessment & Plan: Provider listed Autism in the assessment and stated patient is currently seeing a psychiatrist and receiving therapy.
F79	Unspecified Intellectual Disabilities	<ul style="list-style-type: none"> Social Hx: Provider stated patient is in special school for his intellectual disability since he was 5 years old. Note: According to ICD-10 coding guideline rules, when codes from the Pervasive developmental disorders (F84-) are assigned, then use additional DX code to identify intellectual disabilities (F70-F79). [Intellectual disability if unknown is F79.]
R41.3	Memory Loss NOS	<ul style="list-style-type: none"> HPI: Provider documents patient suffer from memory loss after seizure. Assessment & Plan: Memory loss addressed patient was referred to a specialist

Billing Sample #2



GI Specialist Documentation: Medical record SOAP format (condensed)

DOS: 07/10/2017

Gender: M **DOB:** XX/XX/1992 **Pulse:** 80 **Temp:** 98.8°F **Weight:** 181.40lb **Height:** 5.10 **BMI:** 30.84

HPI: A 25 y.o. male came in today because he was referred by his PCP for chronic constipation. Patient been constipated for over 2 weeks and his abdominal pain has increased significantly over the last 2 days. He has been taking Miralax but is not helping.

Problem List/History:

Social Hx: Diagnosed with having High-functioning Autism at the age of 10. IQ Test Score: IQ of 84. Sees specialists as needed. Patient also suffers from recurrent major depression.

Physical Exam:

Constitutional: No acute distress. Well nourished. Well developed.

Respiratory: Clear to auscultation. No Rales

Cardiology: Tachycardia.

Abdomen: Tender to touch,

Gastrointestinal: GERD

Psychiatric: Depression well controlled with meds

Medications Reviewed:

Citalopram, Flonase, Miralax, Zantac

Assessment and Plan:

Chronic Constipation – recommend drink more water, add fiber to diet and exercise. Keep using the Miralax.

GERD– Increased Zantac to 300 mg daily

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
K59.09	Chronic Constipation	<ul style="list-style-type: none"> HPI: Provider documents patient referred by his PCP for chronic constipation. Assessment & Plan: Provider listed Chronic Constipation & recommended lifestyle changes.
K21.9	GERD	<ul style="list-style-type: none"> Physical Exam: Provider documents in the physical Exam, Gastrointestinal: GERD Assessment & Plan: Provider listed GERD– Increased Zantac to 300 mg daily
F84.0	Autistic disorder	<ul style="list-style-type: none"> Problem List/History: Provider documents patient diagnosed with having High-functioning Autism at the age of 10.
R41.83	Borderline intellectual functioning	<ul style="list-style-type: none"> Problem List/History: IQ Test Score: IQ of 84. Note: According to ICD-10 coding guideline rules, when the IQ is from 70 to 84 assign R41.83, instead of codes from F70 – F79.
F33.9	Recurrent Depression, Unspecified	<ul style="list-style-type: none"> Problem List/History: Provider documented patient also suffers from recurrent major depression. Physical Exam: provider documented Depression well controlled with meds

Billing Sample #3



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Primary Care Physician Documentation: Medical record SOAP format (condensed)

DOS: 05/12/2017

Gender: F **DOB:** XX/XX/2007 **Pulse:** 70 **Temp:** 98.7°F

Weight: 126.80lb **Height:** 4.0 **BMI:** 27.93/ 99%

HPI: 9 y.o. presents for preventive exam. Patient is here for HCY. No recent hospitalizations and no recent illnesses. Mom states patient has had no problems with Asthma and is doing well on the medications. Mom states that patient has been doing well in school and his grades are up ever since an IEP was in place at school. Patient was diagnosed with autistic spectrum disorder and is currently seeing a psychiatrist.

Developmental Assessment:

Attached Note from Psych Eval (12/11/16): Patient is doing better in school. Patient is making friends. Has an IQ of 68. Has an IEP in place in school.

Medications: ProAir, Flovent, Citalopram.

Physical Exam:

Constitutional: No acute distress. Well nourished. Well developed.

Respiratory: Clear to auscultation. No Rales. Asthma is well controlled

Assessment and Plan:

1. Encounter for routine child health exam w/o abnormal findings. (Wellness information, immunization updated, healthy lifestyle, weight loss, and puberty and dental referral)
2. Asthma – Controlled on meds
3. ASD – seeing specialist

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
Z00.129	Routine health exam for child w/out abnormal findings.	<ul style="list-style-type: none"> 9 year old comes in for a Annual Well Child Visit. Code Z00.129 since status of diseases, medications & management by specialist were verified for chronic conditions.
F84.0	Autistic disorder	<ul style="list-style-type: none"> HPI: Provider documents patient was diagnosed with autistic spectrum disorder and is currently seeing a psychiatrist. Developmental Assessment: Provider added a recent psychiatric assessment from a recent visit. IQ score stated to further prove the condition was assessed.
F70	Mild Intellectual Disabilities (IQ 50-70)	<ul style="list-style-type: none"> Developmental Assessment: Provider documented IQ score of 68. Note: According to ICD-10 coding guideline rules, and encouraged by the APA, American , when codes from the Pervasive developmental disorders (F84-) are assigned, then use additional DX code to identify intellectual disabilities (F70-F79). [Intellectual disability if unknown is F79.]
J45.909	Asthma, unspecified	<ul style="list-style-type: none"> HPI: Provider documents asthma doing well on medication. Medications: reviewed. Physical Exam: Respiratory addresses asthma. Assessment & Plan: Asthma addressed again.
Z68.54	BMI Pediatric, ≥ 95 th percentile	<ul style="list-style-type: none"> Vitals: stated in the vitals. Note: Listing the BMI supports Quality and HEDIS Measures.

MORE CODING TIPS:



One way to document & code **chronic conditions** is by utilizing the acronym **MEAT**:

<u>M</u>onitor	<ul style="list-style-type: none">• symptoms• disease progression/regression• ordering of tests• referencing labs/other tests
<u>E</u>valuate	<ul style="list-style-type: none">• test results• medication effectiveness• response to treatment• physical exam findings
<u>A</u>ssess/ <u>A</u>dress	<ul style="list-style-type: none">• discussion, review records• counseling• acknowledging• documenting status/level of condition
<u>T</u>reat	<ul style="list-style-type: none">• prescribing/continuation of medications• surgical/other therapeutic interventions• referral to specialist for treatment/consultation• plan for management of condition

General Notes:

- Chronic Conditions can be coded during any type of visit even if they are stable.
- Verify the condition, any medications, DME, injections, infusions.
- Documentation must support that it was addressed

What are the ICD-10-CM Guidelines?

The **ICD-10-CM Official Guidelines for Coding and Reporting** are rules that supplement the conventions and instructions within the ICD-10-CM classification. Adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).

ICD-10-CM Official Guidelines for Coding and Reporting FY 2018 (October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text

Items underlined have been moved within the guidelines since the FY 2017 version

***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.



Physician's Role

Risk adjustment is an important process that allows the State and Federal government to appropriately allocate revenue to health plans for the high risk members enrolled.

- ❑ Physician data (coding information submitted on physician claims) is critical for accurate risk adjustment.
- ❑ Physician claims data is the largest source of medical data for the risk adjustment models which help to determine how resources are allotted for care of the population.
- ❑ Specificity of diagnosis coding is substantiated by the medical record. Accurate coding helps to best reflect the cost of caring for members/patients:
 - ✓ It demonstrates the level of complexity for the patient encounters.
 - ✓ It is vital to a healthy revenue cycle, and more important, to a healthy patient.
- ❑ Each progress note must:
 - ✓ Support what is coded and billed (ICD-10-CM, CPT, and HCPCS).
 - ✓ “Stand alone” making sure a single service date has proficient data to support the medical decision making.
 - ✓ Be complete and contain legible signature & credentials.
 - ✓ Show medical necessity.



“Document for others as you would want them to document for you.”