

Your Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Practice/Organization Name: \_\_\_\_\_  
 NPI Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_  
 Name of your system vendor, clearinghouse and/or billing service and contact data you may have for them:  
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Email your completed form to us at [ICD-10testing@floridablue.com](mailto:ICD-10testing@floridablue.com)  
 Note: It is critical to successful testing that we collaborate with both providers and their vendors who enable ICD-10 transactions for their clients.

**INSTRUCTIONS**

1. Print this form in order to complete it by hand.
2. Complete your contact information at left of form.
3. Select up to ten (10) scenarios below for practice coding.
4. Instruct your medical coder(s) to complete this document by coding your selected scenarios first using ICD-9 Dx codes followed by ICD-10 Dx codes. Be sure coder(s) understand they are to code in ICD-10 from the selected clinical scenarios vs. coding from ICD-9 to ICD-10 (mapping).
5. Scan and return by email your completed form to [ICD-10testing@floridablue.com](mailto:ICD-10testing@floridablue.com). If you do not have access to a scanner and would like to return your form to us via fax, please fax to 904-997-5571, Attn: Martina Fiorelli.
6. Within two weeks of receipt, Florida Blue will review your completed coding document and provide you with observations for scenarios that we have identified as a potential impact to claims adjudication.

NOTE: If you prefer, you may contact Florida Blue via email [ICD-10testing@floridablue.com](mailto:ICD-10testing@floridablue.com) and you will be provided an Excel spreadsheet on which you can view and code these same scenarios.

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S019	A 3-year-old boy was brought into the office for a scheduled yearly wellness visit but the mother mentioned that he has been coughing and sneezing for the past few days after coming in from outside. He has a history of allergies due to pollen. Physical exam was performed. Patient's general growth was measured, evaluated and discussed along with development progress. Advised parent to administer an over-the-counter allergy medication as needed to treat symptoms and if problems persist or worsen return to office for further evaluation. <b>Impressions:</b> Annual child examination, cough, and allergic rhinitis due to pollen.				
S045	A 13-year-old male was transported via ambulance to the hospital emergency department for severe injuries he sustained escaping from the second story of his burning home. He was unconscious when the paramedics arrived but was found to have multiple burns to his body and multiple injuries to his head as a result of jumping from the 2nd floor window and landing head first on the concrete driveway. An IV line was established and vital signs were taken. Upon arrival at the ER, an x-ray of the head/skull and a CT scan of the head confirm a fracture at the vault of the skull with cerebral laceration and contusion. The patient underwent emergency surgery and was admitted to ICU where he remained unconscious for more than a week and subsequently expired as a result of his head injuries. <b>Impressions:</b> Closed fracture of vault of skull with cerebral laceration and contusion, loss of consciousness greater than 24 hours, without return to pre-existing conscious level, and burning caused by conflagration in private dwelling.				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S047	<p>A 10-day-old male newborn baby was rushed to the hospital emergency room due to bleeding from the nose and mouth. He was examined by the ER physician who ordered tracheal suction, positive pressure ventilation and nasal oxygen to be administered immediately. A chest x-ray result shows multilobar infiltrates. Additionally, the baby sustained a hematoma around the testes resulting from abnormal presentation (breech) during vaginal delivery. The newborn was admitted to pediatric ICU for further monitoring and management.</p> <p><b>Impressions:</b> Pulmonary hemorrhage and birth trauma, other specified.</p>				
S051	<p>A one-week-old newborn baby girl was observed by her mother with bulging fontanelles, increased head circumference, high pitched cry, persistent vomiting, irritability, and respiratory distress. She was immediately taken to the hospital for evaluation of her symptoms. She was examined and evaluated by the on-call Pediatrician who recommended admission. The baby was admitted and multiple diagnostic tests were carried out. The tests results revealed subdural and cerebral hemorrhages and transitory amino-acid metabolic disorder. The plan of treatment was carried out resulting in improvement to the conditions and subsequent discharge to home.</p> <p><b>Impressions:</b> Subdural and cerebral hemorrhages; and transitory amino acid metabolic disorders.</p>				
S053	<p>A 25-day-old premature baby girl was admitted to the hospital for assessment and evaluation of cyanotic attacks with progressive dyspnea. According to the baby's mother she has been having frequent stools, not gaining weight, and is tachypneic. On admission she was limp and grey and appeared to have no air entering the left side of her chest. Stat chest x-ray was performed with results showing a large air-containing cyst in the left lower chest displacing the mediastinum to the right. On physical examination, it was noted the baby's liver was enlarged 2 inches below the costal margin and the spleen was 1½ inches below. Multiple laboratory tests results show abnormalities in different levels.</p> <p><b>Plan:</b> Intravenous infusion of Ganciclovir every 12 hours for 14 to 21 days.</p> <p><b>Impressions:</b> Pneumonia in cytomegalic inclusion disease and late metabolic acidosis of newborn.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S058	<p>A one-week-old newborn baby boy was admitted to the hospital's Neonatal unit for evaluation and management of bleeding gums, nosebleeds, fever and rashes. Physical findings showed signs of bleeding, signs of hypovolemia, an excessive skin bruising, a rash that looks like broken blood vessels in the skin and difficulty breathing. A series of tests results showed elevated level of PT and PTT and decreased platelet count, decreased plasma fibrinogen, and elevated neutrophils which indicates the presence of infection. The baby was placed on oxygen therapy, IV fluid was initiated, and a platelet transfusion was given. Heparin was administered. The baby's PTT, PT, and differential WBC were monitored.</p> <p><b>Impressions:</b> Disseminated intravascular coagulation and transient neonatal neutropenia.</p>				
S059	<p>A two-week-old baby girl was brought to the ED by her parents due to high fever, rapid breathing, lethargy, sunken eyes, sunken fontanel, convulsions, and persistent vomiting. Physical examination findings reveal rapid, shallow breathing, decreased chest expansion, harsh breath sounds. Rales/wheezing sounds were heard over the affected area during inspiration. A series of laboratory tests as well as chest radiographs confirmed dehydration, aspiration pneumonia, and acidosis. The baby was admitted to the neonatal unit of the hospital for further care and management of her conditions.</p> <p><b>Impressions:</b> Dehydration, aspiration, pneumonia and acidosis.</p>				
S061	<p>A month-old baby girl was brought to hospital Emergency Department by her parents for fast, irregular respiration, fever, lethargy irritability, diarrhea, vomiting, poor feeding, high pitched cry, and yellowing of skin. Examination showed respiratory distress, fast heartbeat, and abdominal distention, absence of reflexes on knees, swollen fontanel, cyanosis, and cold/clammy skin. Multiple laboratory tests and a chest x-ray were performed. Blood culture, CSF culture, urine culture, and liver transaminase confirmed septicemia cause by H influenzae and neonatal infection acquired during birth. The plan includes admission to the neonatal unit, IV antibiotic therapy and blood cultures repeated weekly</p> <p><b>Impressions:</b> Septicemia (H influenza), and congenital infection.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S062	<p>A 4-week-old baby boy was found by his mother to be cyanotic with breathing difficulty and increased heart rate. He was rushed to the hospital where oxygen and intravenous fluid were administered immediately. On examination, the baby's heart rate was rapid with prolonged cessation of breathing, presence of chest wall retraction. Nasal flaring was observed, and he had a low grade fever. A chest x-ray was performed and revealed an airless area in the lung confirming the diagnosis of atelectasis. The baby was admitted to Hospital Neonatal Unit for further assessment and management of the condition. Additionally, this baby was born with missing toe on the right foot.</p> <p><b>Impressions:</b> Atelectasis and absence of toe.</p>				
S086	<p>A 10-year-old male patient was brought into the office by his mother with complaints of a dry hacking cough. He was seen and treated 3 weeks ago for an upper respiratory infection that the mother said had cleared up. She has since noticed that he has recently begun to have frequent coughing episodes. Physical exam is done. Patient is encouraged to drink plenty of fluids, and use an over-the-counter cough medicine with an expectorant to loosen up the mucus when coughing. Patient's Mother should call for an appointment if symptoms have not improved in 10 days.</p> <p><b>Impression:</b> Acute bronchitis.</p>				
S102	<p>A 12-year-old female patient seen at the office for symptoms of feeling weak, tired and some shortness of breath. She has been running a fever since last week. She took Tylenol for her fever. She also has asthma and is treated with Advair Diskus. Patient's vital signs are stable without fever at this time. Physical examination reveals some wheezing. Stat CBC ordered and the result shows an elevated WBC, which is indicative of infection. Prescribed antibiotic and instructed the patient and her mother to continue her asthma medication, increase fluid intake, repeat CBC, and follow-up in 3 months unless she is not improved after the course of therapy.</p> <p><b>Impressions:</b> Asthma and leukocytosis.</p>				
S103	<p>A mother brings her 4-year-old son into the office stating he has nasal congestion, a headache, sore throat and swollen eyes. She states that he has a history of allergic rhinitis but has no other chronic problems. Physical exam was performed. Discussed plan on ways to avoid possible allergen triggers with the mother. Ordered OTC antihistamines and decongestants to use as needed. Follow up if symptoms continue to determine any additional treatment options.</p> <p><b>Impression:</b> Allergic rhinitis, cause unspecified.</p>				