Preparing for ICD-10-CM

From

2015 ICD-9-CM

To
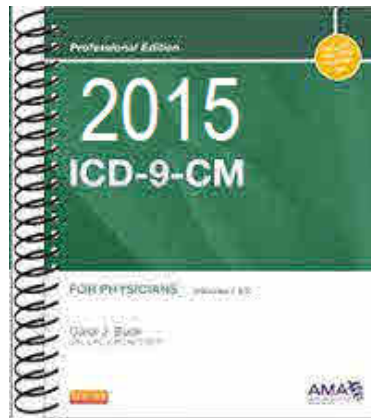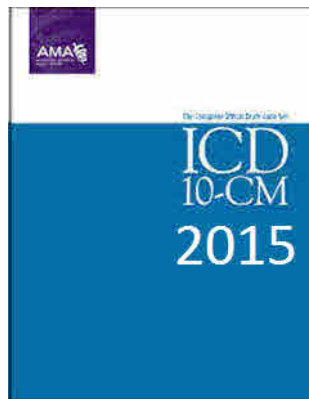
ICD 10-CM 2015

A Free Guide Prepared By:

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Preparing for ICD-10-CM
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For the past thirty-one (31) years, we have learned and used ICD-9-CM when coding for our providers . As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

ICD-10 will replace ICD-9-CM as of October 1, 2015. This can be found at
http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

It is important that non- covered HIPAA entities, such as Entities such as worker's compensation, disability and auto insurers do NOT need to accept ICD-10 codes, but it is highly recommended that they do so simply because covered entities such as doctors, hospitals, and health clinics will be using ICD-10. You can find this by going here:
http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10NoncoveredEntities20140819.pdf

If you wish to know if you are a covered entity under HIPAA, you can go here:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/

There are now rumors which state that ICD-10 wont happen at all, that ICD-10 will be bypassed and we will go straight to ICD-11 and ICD-10 won't happen at all. These are just rumors. Anytime there are proposed changes, there are rumors because there are some who want to brag that they told everyone first. It also allows them to sound important and you can see this in some offices where you are in the cube farm and the office wannabe comes to you and says, Guess what I heard, or I was told...What they say sounds important and real, so you spend hours of work time trying to find out if what you were told is true. I see this all the time where someone will go on the internet and ask: Can someone settle an office bet, our coders say that ICD-10 wont happen at all and another department says it will be delayed until 2017. There is an old saying in coding, "If it isn't documented, it doesn't exist or it didn't happen." When ICD-10 becomes effective, it's success is dependent on the provider's documentation. If someone says anything, you want to see the documentation to support what they say. I am providing links to official references to support what I am providing.   Well, ICD-10 IS going to happen and as of today, May 7, 2015, everything points to ICD-10 still taking place on October 1, 2015. A bill was before Congress to make another delay in the effective date, but, the bill went nowhere. The image below is a screen capture of the Centers for Medicare and Medicaid (CMS) ICD-10 website. As you can see, it contains a countdown clock to when ICD-10 become effective. As of today, you can see that YOU have 146 days left to get ready.

You can go and keep track of this clock at
http://www.cms.gov/Medicare/Coding/ICD10/index.html
As you can see, there is NOTHING that says ICD-10 wont happen and ICD-10 will be bypassed so that we pass go and start with ICD-11.
If you go to the World Health Organization's ICD-11 website, you see the following:

There is nothing that even mentions that ICD-11 will bypass ICD-10.

You can go to this website by going to:
http://apps.who.int/classifications/icd11/browse/l-m/en

ICD-10 isnt mysterious, it isn't scary. I will repeat this many times in this guide as a means of convincing you because there are some who want you to be scared. Fear can make money. I will say that ICD-10 will be a huge change to what we code, not how we code. To make it as simple as I can, the disease you treat won't change. Chest pain will still be chest pain, chicken pox will still be chicken pox, and pink eye will still be pink eye but we will look for conjunctivitis instead of pink eye. What will change is the code for those diseases or injuries. Let me show you:

Chest Pain:

Under ICD-9: 786.50 or 786.59

Under ICD-10: R07.9

Chicken Pox:

ICD-9-CM: 052.9
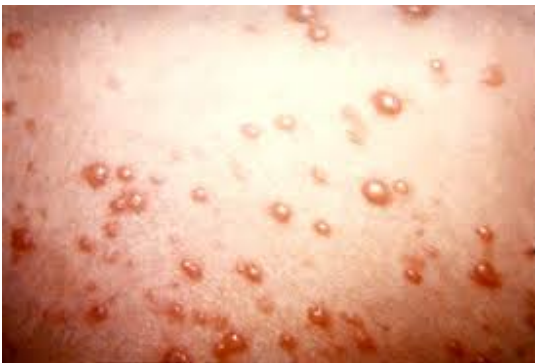
ICD-10-CM: B01.9

Conjunctivitis

ICD-9-CM: 372.39

ICD-10-CM: H10.9

As you can see, the diseases themselves did not change. The only thing that changed was the code for the disease. You are going from a 3, 4, or 5 digit code to a letter plus numbers code. ICD-10 can go as high as seven digits and that opens the door to more codes being available for you to select.
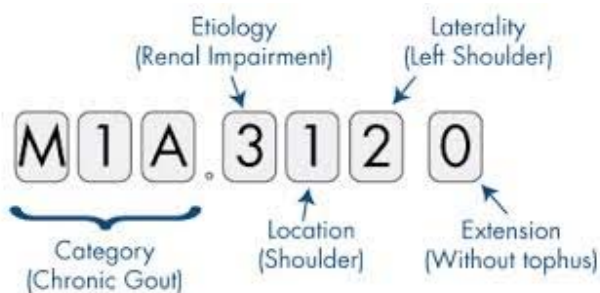
To be very honest with you, if you can successfully code ICD-9, you will have no problem coding ICD-10. Im 62 years old and I can do it. If I can do it, there is no reason why you cant either of you have the proper training, and I do have the training that allows me to code and to code correctly. The process of coding wont change. Coding will not succeed if your coder has NO training in the process of coding. Right now those that don't know how to code are going to the internet to have someone who can code, code for them. Too many times Ive seen the following:

I don't have my coding books with me. Can someone tell me what code to use with a cranialrectalectomy? Or What is the code for cranial-rectal blockage? Or We have a disagreement with our coding department and we need someone to settle this dispute. Or Someone told us that we cannot use code XXX.XX with a cranialrectalectomy. What code can we use to get it paid? Im sure some of these sound familiar to you or you may have seen them before.

In case you were wondering, the following is cranial-rectal blockage:

There is no icd-9 code for this, but maybe ICD-10 code **R19.8** - Other specified symptoms and signs involving the digestive system and abdomen may come close. Yes, Virginia, there is a code for that.

In order for ICD-10 to succeed, doctors need to improve their documentation of the visit. ICD-9 was forgiving to poor or incomplete documentation. ICD-10 is easy but it will take work to make it easy.

If the documentation shows, "OM", many of us know this probably means Otitis Media. DM probably means Diabetes Mellitus. Under ICD-9-CM, you have the following code for Otitis Media:

382.9 - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient.   ICD-10 has more codes available for the diagnoses. Where you had one code in ICD-9, you may have 12 or more codes for that same diagnosis.

Under ICD-10-CM, you have the following codes for Otitis Media:

H66.9 **Otitis media**, unspecified

H66.90 **Otitis media**, unspecified, unspecified ear

H66.91 **Otitis media**, unspecified. right ear

H66.92 **Otitis media**, unspecified, left ear

H66.93 **Otitis media**, unspecified, bilateral

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with pain in the left ear, the right ear or in both ears, but all the doctor wrote is "OM" and nothing more. This asks questions that you cant answer. If you have to contact the doctor for additional information, this could cause you to delay the submission of the claim and what could happen is that the delay could cause the claim to be denied for untimely filing. An incorrect code could cause the claim to be placed into review, delay the claim while the insurance company waits for you to send them copies of the medical record or to deny the claim because the code doesn't support the service

that was provided.   Under ICD-10-CM you need more anatomical information to select the best possible code. Many specialties are anatomically based specialties. This means you need to document left, right, or both.

As I stated, the process of coding wont change. Many coding conventions wont change.

ICD-9-CM has the following coding conventions:

A. Conventions for the ICD-9-CM

The conventions for the ICD-9-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the index and tabular of the ICD-9-CM as instructional notes. The conventions are as follows:

1. Format:

The ICD-9-CM uses an indented format for ease in reference

2. Abbreviations

a. Index Abbreviations

NEC "Not elsewhere classifiable"

This abbreviation in the index represents "other specified." When a specific code is not available for a condition the index directs the coder to the "other specified" code in the tabular.

b. Tabular Abbreviations

NEC "Not elsewhere classifiable"

This abbreviation in the tabular represents "other specified." When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the "other specified" code.

(See Section I.A.5.a. "Other" codes)

NOS "Not otherwise specified"

This abbreviation is the equivalent of unspecified.

(See Section I.A.5.b., "Unspecified" codes)

3. Punctuation

[ ] Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the index to identify manifestation codes.

(See Section I.A.6. "Etiology/manifestations")

( ) Parentheses are used in both the index and tabular to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

: Colons are used in the Tabular list after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

4. Includes and Excludes Notes and Inclusion terms

Includes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Excludes: An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

Inclusion terms: List of terms are included under certain four and five digit codes. These terms are the conditions for which

that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

5. Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" (usually a code with a 4th digit 8 or fifth-digit 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate "other" codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

6. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code

title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.

In addition to the notes in the tabular, these conditions also have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

The most commonly used etiology/manifestation combinations are the codes for Diabetes mellitus, category 250. For each code under category 250 there is a use additional code note for the manifestation that is specific for that particular diabetic manifestation. Should a patient have more than one manifestation of diabetes more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition. The category 250 diabetes codes should be sequenced first, followed by the manifestation codes.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.

See Section I.B.9. "Multiple coding for a single condition".

7. "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

8. "With"

The word "with" in the alphabetic index is sequenced immediately following the main term, not in alphabetical order.

9. "See" and "See Also"

The "see" instruction following a main term in the index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

Now, let's look to see what ICD-10 conventions show us:

ICD-10-CM Coding Conventions:

A. Conventions for the ICD-10-CM
The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Index and Tabular of the ICD-10-CM as instructional notes.

The Alphabetic Index and Tabular List
The ICD-10-CM is divided into the Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition. The Index is divided into two parts, the Index to Diseases and Injury, and the Index to External Causes of Injury. Within the Index of Diseases and Injury there is a Neoplasm Table and a Table of Drugs and Chemicals.

> *See Section I.C2. General guidelines*
> *See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects*

Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. All codes in the Tabular List of the official version of the ICD-10-CM are in bold. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference

Use of codes for reporting purposes
For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

Placeholder character
The ICD-10-CM utilizes a placeholder character "X". The "X" is used as a 5th character placeholder at certain 6 character codes to allow for future
expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50. Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

7th Characters
Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

Abbreviations
a. Index abbreviations

NEC "Not elsewhere classifiable"
This abbreviation in the Index represents "other specified". **W**hen a specific code is not available for a condition, the Index directs the coder to the "other specified" code in the Tabular.

b. Tabular abbreviations
NEC "Not elsewhere classifiable"
This abbreviation in the Tabular represents "other specified". When a specific code is not available for a condition the Tabular includes an NEC entry under a code to identify the code as the "other specified" code.

NOS "Not otherwise specified"
This abbreviation is the equivalent of unspecified.

Punctuation
[ ] Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Index to identify manifestation codes.

( ) Parentheses are used in both the Index and Tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.
: Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

Use of "and"
When the term "and" is used in a narrative statement it represents and/or.

Other and Unspecified codes
a. "Other" codes

Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate "other" codes in the Tabular. These Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

Includes Notes

This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Index may also be assigned to a code.

Excludes Notes

The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they

indicate that codes excluded from each other are independent of each other.

a. Excludes 1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

b. Excludes2

A type 2 excludes note represents "Not included here". An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the

underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.

In addition to the notes in the Tabular, these conditions also have a specific Index entry structure. In the Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
See Section I.B.7. Multiple coding for a single condition.

"And"
The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

"With"
The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

"See" and "See Also"
The "see" instruction following a main term in the Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

"Code also note"

A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

Default codes

A code listed next to a main term in the ICD-10-CM Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome.

As you can see, the guidelines for ICD-9-CM are not that different than those for ICD-10-CM. The ICD-10 coding convention looks just like the ICD-9 coding conventions, so what's so scary about ICD-10? Not scary, right? Don't let anyone scare you about ICD-10.

If you look at the following, you can see the similarity between ICD-9-CM and ICD-10-CM:

ICD-9-CM

005 Other food poisoning (bacterial)
> *Excludes: salmonella infections (003.0-003.9)*
> *toxic effect of:*

food contaminants (989.7)
noxious foodstuffs (988.0-988.9)

005.0 Staphylococcal food poisoning
Staphylococcal toxemia specified as due to food

005.1 Botulism food poisoning
Botulism NOS
Food poisoning due to Clostridium botulinum
Excludes: infant botulism (040.41)
wound botulism (040.42)

005.2 Food poisoning due to Clostridium perfringens [C. welchii]
Enteritis necroticans

ICD-10-CM

A05   **Other bacterial foodborne intoxications, not elsewhere classified**

Excludes: Escherichia coli infection (A04.0-A04.4)
listeriosis (A32.-)
salmonella foodborne intoxication and infection (A02.-)
toxic effect of noxious foodstuffs (T61-T62)

A05.0   **Foodborne staphylococcal intoxication**

A05.1   **Botulism**

Classical foodborne intoxication due to Clostridium botulinum

A05.2   **Foodborne Clostridium perfringens [Clostridium welchii] intoxication**

Enteritis necroticans Pig-bel

A05.3   **Foodborne Vibrio parahaemolyticus intoxication**

A05.4   **Foodborne Bacillus cereus intoxication**

A05.8   **Other specified bacterial foodborne intoxications**

A05.9   **Bacterial foodborne intoxication, unspecified**

As you can see there isn't too much difference between how ICD-9-CM and ICD-10-

CM looks. Code 005 series becomes A05 series. You can see that the coding conventions still take place with ICD-10-CM.

If you look at the introduction of each section of ICD-9-CM, they are similar to the instructions in ICD-10-CM:

ICD-9-CM

1. INFECTIOUS AND PARASITIC DISEASES (001-139.8)

> *Includes: diseases generally recognized as communicable or transmissible as well as a few diseases of unknown but possibly infectious origin*
> *Excludes: acute respiratory infections (460-466)*
> > *carrier or suspected carrier of infectious organism (V02.0-V02.9)*
> > *certain localized infections*
> > *influenza (487.0-487.8, 488)*
> Note: Categories for "late effects" of infectious and parasitic diseases are to be found at 137-139.

ICD-10-CM

Certain infectious and parasitic diseases
(A00-B99)

Includes diseases generally recognized as communicable or
:   transmissible

Use additional code (U80-U89), if desired, to identify the antibiotic to which a bacterial agent is resistant.

Excludes: carrier or suspected carrier of infectious disease (Z22.-)
certain localized infections - see body system-related
        chapters
        infectious and parasitic diseases complicating pregnancy,
        childbirth and the puerperium [except obstetrical tetanus

period [except tetanus neonatorum, congenital syphilis, perinatal gonococcal infection and perinatal human immunodeficiency virus [HIV] disease] (P35-P39) influenza and other acute respiratory infections (J00-J22)

When we look at the Index of ICD-9-CM and ICD-10-CM, we can, again, see similarities:

ICD-9-CM

AAT (alpha-1 antitrypsin) deficiency **273.4**

AAV (disease) (illness) (infection)--_see_ **Human immunodeficiency virus** **(disease) (illness) (infection)**

Abactio--_see_ **Abortion, induced**

Abactus venter--_see_ **Abortion, induced**

Abarognosis **781.9**

Abasia (-astasia) **307.9** View Subentries

Abderhalden-Kaufmann-Lignac syndrome (cystinosis) **270.0**

Abdomen, abdominal--_see also_ condition View Subentries

Abdominalgia **789.0** View Subentries

Abduction contracture, hip or other joint--_see_ **Contraction, joint**

Abercrombie's syndrome (amyloid degeneration) **277.39**

Table of Drugs ICD-9-CM

ICD-9 Table of Drugs and Biologicals

Substance	Poisoning	Accident	Therapeutic Use	Suicide Attempt	Assault	Undetermined
1-propanol	980.3	E860.4	-	E950.9	E962.1	E980.9
2-propanol	980.2	E860.3	-	E950.9	E962.1	E980.9
2, 4-D (dichlorophen-oxyacetic acid)	989.4	E863.5	-	E950.6	E962.1	E980.7
2, 4-toluene diisocyanate	983.0	E864.0	-	E950.7	E962.1	E980.6
2, 4, 5-T (trichloro-phenoxyacetic acid)	989.2	E863.5	-	E950.6	E962.1	E980.7
14-hydroxydihydro-morphinone	965.09	E850.2	E935.2	E950.0	E962.0	E980.0
ABOB	961.7	E857	E931.7	E950.4	E962.0	E980.4
Abrus (seed)	988.2	E865.3	-	E950.9	E962.1	E980.9
Absinthe	980.0	E860.1	-	E950.9	E962.1	E980.9

Table of Drugs ICD-10-CM

ICD-10 Table of Drugs and Biologicals

Substance	Poisoning Accidental Unintentional	Poisoning Intentional Self harm	Poisoning Assault	Poisoning unetermined	Adverse effect	Underdosing
1-propanol	T51.3x1	T51.3x2	T51.3x3	T51.3x4	--	--
2-propanol	T51.2x1	T51.2x2	T51.2x3	T51.2x4	--	--
2,4-D (dichlorophen-oxyacetic acid)	T60.3x1	T60.3x2	T60.3x3	T60.3x4	--	--
2,4-toluene diisocyanate	T65.0x1	T65.0x2	T65.0x3	T65.0x4	--	--
2,4,5-T (trichloro-phenoxyacetic acid)	T60.1x1	T60.1x2	T60.1x3	T60.1x4	--	--
14-hydroxydihydro-morphinone	T40.2x1	T40.2x2	T40.2x3	T40.2x4	T40.2x5	T40.2x6
ABOB	T37.5x1	T37.5x2	T37.5x3	T37.5x4	T37.5x5	T37.5x6
Abrine	T62.2x1	T62.2x2	T62.2x3	T62.2x4	--	--
Abrus (seed)	T62.2x1	T62.2x2	T62.2x3	T62.2x4	--	--
Absinthe	T51.0x1	T51.0x2	T51.0x3	T51.0x4	--	--
- beverage	T51.0x1	T51.0x2	T51.0x3	T51.0x4	--	--

Under ICD-9, Accidental poisoning by Absinthe would be 980.0.
Under ICD-10, this code would be T51.0x1
When looking at T51.0, you find this:
T51.0 Toxic effect of ethanol
Toxic effect of ethyl alcohol Excludes2: acute alcohol intoxication or "hangover" effects
 drunkenness pathological alcohol intoxication
T51.0x Toxic effect of ethanol
T51.0x1 Toxic effect of ethanol, accidental (unintentional)
Toxic effect of ethanol NOS

Again, both look the same, not so scary, right?

Again, with ICD-9-CM, you have 3, 4, or 5 digit codes. With ICD-10-CM, you can have up to 7 digits with a code. That is one big difference between ICD-9-CM and ICD-10-CM.

Some guidelines exist in ICD-9-CM, but do not exist in ICD-10-CM. For example:

Some guidelines changed or do not exist in ICD-10

ICD-9
- 15. Admissions/Encounters for Rehabilitation
- When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.
- Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.

ICD-10
Does not exist in ICD-10

If you look at the following, you can see the differences between ICD-9-CM and ICD-10-

Chapter	ICD-9-CM	Descriptor	ICD-10-CM	Descriptor	# Codes **
1	001-139	Infectious and Parasitic Diseases	A00-B99	Certain infectious and parasitic diseases	455
2	140-239	Neoplasms	C00-D48	Neoplasms	622
3	240-279	Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	696
4	280-289	Diseases of Blood and Blood Forming Organs	E00-E90	Endocrine, nutritional and metabolic diseases	2,230
5	290-319	Mental Disorders	F00-F99	Mental and behavioural disorders	1,163
6	320-389	Diseases of Nervous System and Sense Organs	G00-G99	Diseases of the nervous system	792
7	390-459	Diseases of Circulatory System	H00-H59	Diseases of the eye and adnexa	296
8	460-519	Diseases of Respiratory System	H60-H95	Diseases of the ear and mastoid process	214
9	520-579	Diseases of Digestive System	I00-I99	Diseases of the circulatory system	3,885
10	580-629	Diseases of Genitourinary System	J00-J99	Diseases of the respiratory system	1,439
11	630-677	Complications of Pregnancy, Childbirth, and the Puerperium	K00-K93	Diseases of the digestive system	1,560
12	680-709	Diseases Skin and Subcutaneous Tissue	L00-L99	Diseases of the skin and subcutaneous tissue	322
13	710-739	Diseases of Musculoskeletal and Connective Tissue	M00-M99	Diseases of the musculoskeletal system and connective tissue	1,374
14	740-759	Congenital Anomalies	N00-N99	Diseases of the genitourinary system	1,046
15	760-779	Newborn (Perinatal) Guidelines	O00-O99	Pregnancy, childbirth and the puerperium	600
16	780-799	Signs, Symptoms and Ill-Defined Conditions	P00-P96	Certain conditions originating in the perinatal period	213
17	800-999	Injury and Poisoning	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	240
18	V01-V89	Classification of Factors Influencing Health Status and Contact with Health Service	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1,585
19	E800-E999	Supplemental Classification of External Causes of Injury and Poisoning	S00-T98	Injury, poisoning and certain other consequences of external causes	1,235
20			V01-98	External causes of morbidity and mortality	714
21			Z00-Z98	Factors influencing health status and contact with health services	2,441
22			U00-U99	Codes for special purposes	
				Total Codes	**23,122**

Note: ** Information Obtained from data compiled by AHA & AHIMA

Under ICD-9, you have 19 Chapters and under ICD-10, you have 22 Chapters.

ICD-9-CM codes are made up of 3, 4, or 5 numbers.

ICD-10-CM Codes are made up of a letter and numbers. ICD-10-CM codes can go as high as 7 digits.

I know I repeat myself, but, to learn something, we repeat it. My French teacher's most used word was Repeater, Repeater, Repeater. Unfortunately, I failed French so I switched to German and heard the word wiederholen again and again. My German wasn't the best, but, I lived in Germany from 1975 to 1978. I met my German teacher in 1993 and thanked him for teaching me German. I was such an outstanding student that he said he never remembered me. Oh well, Cest Le Guerre!

Former V Codes are now Z Codes

- One of the most popular V Codes was the Well baby Check which used V20.2 Routine infant or child health check.

- Under ICD-10, this has been changed to
- Z00.1 Encounter for routine child health examination Encounter for development testing of infant or child Excludes1: health supervision of foundling or other healthy infant or child (Z76.1-Z76.2)
- Z00.10 Encounter for routine child health examination without abnormal findings Encounter for routine child health examination NOS
- Z00.11 Encounter for routine child health examination with abnormal findings
- Use additional code to identify abnormal findings

To show you another example of the change from ICD-9 to ICD-10, Look at the image below of The White House. President Obama is working in his office in the west wing. Michele Obama is working in the white house garden and Bo the dog is looking out the middle window on the second floor. The address of the White House is 1600 Pennsylvania Avenue.

ICD-9-CM

1600 Pennsylvania Avenue

ICD-10-CM

W01.9 Pennsylvania Avenue

Now, the White House is under ICD-10. The building is still white, President Obama is still in his office in the west wing. Michelle Obama is still working in the garden. Bo the dog is still in the middle window of the second floor, but the address is no longer 1600 Pennsylvania Avenue. The address is now W01.9 Pennsylvania Avenue. That's it! Not so scary, isn't it?

What to do to be ready by

October 1, 2015!

So, what do we have to do to be ready by this date? Using common sense, the following should be performed for seamless transition.

Training/Retraining/Certification

If you have coders on your staff who do NOT have the training in Coding, send them to school to learn how to code. Again, if they cant code ICD-9, they wont be able to code ICD-10. Going to the internet will not help you for several reasons. The person giving the answer may not be providing a correct answer. Many professional coder websites are informing those asking for codes that their website is not the place to ask for codes. The coders who do have the training will be very busy with their own work and wont have the time to help. You are never too old to learn how to code.
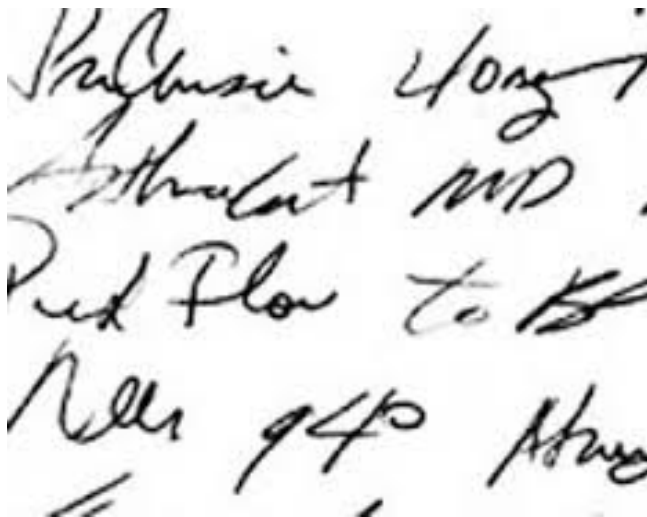
The American Academy of Professional Coders (AAPC) Certified Coders will need to undergo retesting in ICD-10 for recertification. The Professional Association of Healthcare Coding Specialists (PAHCS)) certified coders do not. I know of some associations who are testing their certified members with current tests and if the member fails the

test, their certification is being revoked. When someone has recognized initials after their name, they should be the people answering questions being asked instead of asking the questions.

Medical Record Documentation

Providers need to be more detailed with health record documentation and the importance of how their documentation improves coding and improves practice revenue.

Can you code based on the following?

What does the above image of a real document say? If you cant read it, no one else can. Ask yourself, will your documentation protect you in a malpractice lawsuit?

Is the following record entry, legible and complete?

Record Example:

CC: Pt here for follow up
S: Here to be followed up.
O: Appears to be doing better
A: Healing well
P: Return in 3 weeks for follow up.

This example may be extreme, but as a patient, Ive had doctors document some of my visits like this or worse and they're billing for the highest level of office visit or for a high level 4 consultation. Imagine how you would feel if you received a bill for $1,000 when the bill should be around $200? Would you pay it? Ive seen documentation like the example above and the doctor billed both me and my insurance company for a 99255 consultation. Unfortunately the medical record doesn't support a consultation AND it doesn't support a 99255 consultation. It barely supports a 99201 office visit or doesn't support a visit at all. I recommend that every practice do an internal audit by checking your current medical record documentation. Also, look for the signs that you may have a problem now. Signs can be unpaid claims, claims that are down coded by the insurance company. What this means is that you sent a claim for a 99204 office visit and the insurance company down coded and paid for a 99202 or 99201 visit. Your claims are being reviewed instead of being paid. The insurance company is demanding the medical record with every claim for a 99204, 99205, 99214 or 99215 office visit. You receive numerous requests for medical records or there is an increase in paid claims refund demands. October 1, 2015 is not a reboot. The problems you face now, you will continue to face when we move to ICD-10. On a side note, Ive met with doctors who have claims problems. These same doctors would file for bankruptcy thinking that bankruptcy would make things better, but because they continued to do the same things that they did to cause the problem, the problems came back after bankruptcy. In patient terms, if you have a constantly sick patient who is morbidly obese, chain smokes 4 cartons of cigarettes per day, drinks a case of beer a day, snacks on potato chips while on the sofa for 18 hours of day, and whose form of exercise is to reach for the television remote control, will need to make changes to their life and lifestyle if they wish to continue to lead a long healthy life.

Current Manuals

Current ICD-10 Manuals will need to be obtained and used. If you try to use ICD-9-CM codes after October 1, 2015 on dates of service after October 1, 2015, your claims will be denied. That doesn't mean that you wont still need to use ICD-9 codes after October 1, 2015. Why? Steve Verno visits your practice on Wednesday, September 30, 2015. Steve forgot to give you insurance information or he provided you with his insurance information, but, due to an error with data entry, your system shows Steve as uninsured or self pay. In October 2015, you send Steve a statement for his September 30 visit. Steve doesn't respond thinking that he gave you his insurance information or that this is a simple administrative mistake that you will fix. You send Steve a second statement in November 2015. Steve calls you and gives you his insurance information, but, for reasons unknown a claim is never produced, your system still shows Steve as self pay. Steve gets a third statement in December 2015, so he thinks this is still a mistake because he just gave you his insurance information. Can this happen? Yes, it has happened to me. The practice billed an insurance plan that I did not have.   In January 2016, you send Steve's account to your debt collection agency. Steve disputes the bill because he has insurance that pays for the visit.   In March 2016, you receive copies of Steve's insurance cards. Both are Federal Government plans. Steve's plans have a one year time limit to send a claim, so there is still time to send the claim without it being denied for untimely filing. But, even though it is now March 2016, you cant use ICD-10 codes because the ICD-10 codes were not effective on September 30 when Steve was seen. You will need to send the claim using ICD-9 codes. When October 1, 2015 arrives, put your ICD-9 coding manuals away in a safe place. CMS publish Medicare Learning Manners SE1239 which states the following:

ICD-9-CM codes will not be accepted for services provided on or after October 1, 2015.

ICD-10 codes will not be accepted for services prior to October 1, 2015.

You can download SE 1239 by going to
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1239.pdf

Updated Software

Medical Billing software needs to be updated to include both ICD-9-CM and ICD-10. This is because with an October 1, 2015 effective date, Claims for September 30th and before September 30th dates of service will still use ICD-9 Codes.

It will be important to train your staff to double check their work to ensure that they didn't select the wrong code set when entering the patient and visit information into your software.

To prepare for ICD-10, the paper CMS 1500 claim form was changed in April 2015. Block 21, diagnosis codes has the ability to add more codes that on previous claim forms. Instead of four (4) diagnosis codes, you can now enter twelve (12) diagnosis codes and there is a small box located within block 21. In this box, you enter which code set you are entering in block 21. If you are entering ICD-9-CM codes, you enter a 9 in this small box. If you are entering ICD-10-CM codes, you enter a zero (0) in this box.

The image above shows ICD-9-CM codes.
786.50: Chest pain
724.2: Back pain
307.81: Headache
525.9: Toothache
9 = ICD-9-CM Codes

The image below shows ICD-10-CM codes for the same diagnoses.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind.	0
A. R07.9	B. M54.9	C. R51	D.	K08.8
E.	F.	G.	H.	
I.	J.	K.	L.	
24. A. DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.

R07.9: Chest Pain
M54.9: Back Pain
R51: Headache
K08.8: Toothache
0 = ICD-10 Codes

As you can see this isn't scary at all. If you looked at Block 21 above, you would see that it looks very familiar. If I didn't tell you that those codes are ICD-10 codes, you may have thought that these were codes you've been using all along. The chest pain is still chest pain, the back pain is still back pain, the headache is still a headache and a toothache will stay a toothache.   Again, Im here to show you that ICD-10 isnt scary and the change is good. If you look at the image below, you will see the same diseases coded as ICD-11 codes.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind.	1
A. ME46.4	B. GA5Z	C. MA0E	D.	EB01.Z
E.	F.	G.	H.	
I.	J.	K.	L.	
24. A. DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.

To repeat myself, it doesn't matter what code set we use for diagnosis coding, whether it be ICD-1, ICD9, ICD-10, ICD-11 or ICD1billion, the disease stays the same, the process of coding stays the same, only the code changes.

When attending medical billing conventions, Ive met with many medical billing software vendors and those Ive met have updated their software to comply with ICD-10 and can store both ICD-9 and ICD-10 codes. You do want to check with your software vendor to see if you need an

upgrade so that your software is compliant with ICD-10, as well as to see how much that upgrade will cost you.

Check with your claim clearinghouse to see what they have done to be ready and if not ready when they will be ready. Have they conducted any tests with the insurance plans that they send claims to? Also, if your claims contain ICD-9 codes, how much will it cost you to have them convert those codes to ICD-10 when you send them claims, if they offer that service. You also want to see about testing your claims to see if you wont have any issues with the changes. Medicare has been performing testing for ICD-10, but, that test period has now ended.

Updated Carrier Policies and Procedures
Providers who are contracted and whose contract has language where the provider agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes and to see what these new policies contain. The diagnosis codes that support medical necessity may have been updated to ICD-10 codes. If you have agreed to comply with those policies, you want to make sure that you know what you've agreed to so that you don't start seeing a decline in your practice revenue. These same policies can be used to dispute a denial so that you obtain a payment for what you provided to the patient. As an example, ABC Insurance may have a policy regarding cranialrectalectomies where the diagnosis for medical necessity is X000 (fake code). It is in your medical opinion that Mr. Johnson requires a cranialrectalectomy. His diagnosis is V111 (Fake Code), so having a diagnosis of V111 wouldn't make providing a cranialrectalectomy medically necessary, therefore ABC Insurance would deny the procedure. If you diagnose Mr. Johnson with a diagnosis of X000, then you can show medical necessity for the procedure. You should find out if there are going to be any claims payment delays due to the changeover to ICD-10 as this may affect contract payment timeframes. My doctor sent me for testing due to changes with my health plan preventive medicine procedures. The Affordable Care Act now allowed these procedures to be covered services. The claim was denied because the provider that rendered the test used codes that were not documented by my provider and were codes that were deleted years

ago. That was mistake number one. The test provider's office informed me that it was my responsibility to recode the claim and to pay the claim in full. That was mistake number two. I obtained a copy of the test policy and used that to dispute the denial showing that the diagnosis codes selected by my PCP were the correct codes to support medical necessity per the insurance company's policy. The test provider recoded the claim using the diagnosis codes provided by my primary care provider. In the end, the denial was overturned and the claim was paid. I sent a check to pay for my coinsurance responsibility. Technology today allows us to do things that we couldn't do 5-10 years ago. We can obtain policies that are in adobe pdf format and store those on a flash drive or micro sd card. Once stored, we have access to them at anytime, anywhere. Medicare SE1239 is a 87kb in size document. You can easily store approximately 700 million copies of this document on a 64 Gigabyte flash drive which costs approximately $18.00.

Updated Software:
Your current software may have only ICD-9 codes. You will need to ensure that your software has the ability to have both ICD-9 and ICD-10 codes. This is valuable for all services rendered prior to October 1, 2015. When coding, some practices or coders use software to assist them. Im an old school coder who opens the coding book, as a biller, I may use the software as a tool to dispute a claim or to dispute a claim denial. As an example, when I was seen by a doctor, he sent me a bill for a 99244 consultation instead of a routine office visit. I requested the medical record and in my dispute, I showed that the visit was NOT a 99244, but was a 99203. The software I used to help me with my dispute is called Turbocoder. I have provided a link to Turbocoder which is www.turbocoder.net.   I am able to copy the code definition to my dispute. Turbocoder also contains the ICD-10 codes for a diagnosis. The doctor agreed with me and I paid for the 99203 visit. I do not use my knowledge to refrain from paying my medical bills. I am forbidden, by my Kryptonian father, from using my powers for evil.

Updated Compliance Plans
Practices and Billing Companies should update their compliance plans regarding ICD-10 coding. Extra attention should be directed to

performing routine internal audits of charts and claims as a means of identifying fraud, waste, abuse and embezzlement.

Updated Coding Denial Appeals

If the billing company or provider practice is using a cookie cutter appeal, then the appeals should be reviewed and updated to conform to ICD-10 standards. I have created my own cookie cutter appeals, but with each appeal or dispute resolution, I have to change it for each appeal because the patient is different, the visit is different, the codes are different and the laws having jurisdiction are different. The appeal may reference an ICD-9 code, so your updated appeal template should reference the current ICD-10 code AND your appeal should have the support of the medical record documentation. As an example: When you look at the medical record, you will see that Dr. Jones documented that Steve Verno complained of chest pain. When you look at the coding manual, you can see that chest pain, unspecified is identified as 786.50 or 786.59. You should change the chest pain ICD-9 code to the R07.9 ICD-10 code.

Updated Superbills

If the practice is using a superbill that contains ICD-9 codes, these should be replaced with the appropriate ICD-10 code(s). I want to caution you that do NOT look up the ICD-10 codes based on ICD-9 codes that may be on the superbill. It is possible that the ICD-9 code on the superbill was entered incorrectly, is outdated or was deleted. I look up the disease itself to find the correct ICD-10 code. As an example, a superbill may contain the disease HIV. The ICD-9 code for HIV is 042. When creating the superbill, someone may have felt that 042 wasn't specific enough, so they added two additional numbers making HIV 042.59. There is no diagnosis code of 042.59, so when updating the superbill, Im not going to look for 042.59, Im going to look for HIV. When I look up HIV in the ICD-10 coding manual, I find B20. I want to caution you that the one ICD-9 code on your superbill may turn out to be 2, 3, or possibly 25 ICD-10 codes. That one page superbill may end up becoming a 2-3 or 4 page superbill. When you have updated your superbill, it might be a good idea to verify that the codes are 100% true, accurate, and correct. A good practice to follow is to update your

superbills with changes that take place with codes. The disease code may change, be deleted or be modified. The person making the changes should be trained in coding.

Fraud and Abuse
Continue to fight fraud, abuse and any up/downcoding issues.
As with any changes there is always the fear that using something new is better resolved by downcoding a claim to remain under the "radar" Finding more codes available could lead to temptation to upcode or to submit a false claim to increase practice revenue. One thing I wish to let you know, trying to keep under the radar by downcoding wont keep you off the radar. Ive been in this business for more than 20 years, Ive been involved with edits and I can say that when you do everything right, you never have to fear an audit. I welcome audits. Ive actually called and requested an audit simply to make sure Im doing everything correctly.

Financial Readiness
There are practices that can go days or weeks with a reduction in revenue. Some may not be so lucky. That claim you sent on October 1, 2015 may take up to 45 days to be paid. That means you may not see any payment until at least January 2016. Ive met doctors who live day to day through payday loans and credit card advances. You want your patients to be healthy and you want your practice to be healthy. Make sure that you can last for several months until there is a continual flow of revenue coming into your practice. Claims problems can cause a slowdown or halt to that revenue flow.

Post October 1, 2015

This is when you are vulnerable. You've worked hard to be ready for the change to ICD-10. You improved your documentation, your coder is not only trained, they are also certified as a coder, your software is updated and you passed the electronic claims submission tests, plus your superbill is converted to ICD-10 codes. You've submitted your October 1, 2015 claims and you wait for the payment to come in. This is where you need to be more vigilant. There may be signs of problems. These signs are in the form claim denials, medical record requests, pended claims, or refund demands. Take a closer look at your practice now.

Are you having these problems now? Reviewing your practice is no different than treating your patient. Your patient may come in with a sign or symptom that can define a serious medical problem. Your practice also has signs and symptoms that may define a serious financial, coding or billing problem. These problems will remain when ICD-10 becomes effective or your problems may worsen to where your practice is in serious jeopardy. If the date is March 2016 and you still have unpaid/non-denied claims from January 2015, you need to find answers and you need to fix those problems. Your practice is also your patient and you want your patient/practice to be healthy. If you need assistance or training in Accounts Receivables Management, Claim Dispute resolution aka Appeals, ERISA, or other areas, you can contact The Medical Association of Billers, the Professional Association of Healthcare Coding Specialists, The National Healthcare Leaders Association, or Billing-Coding Advantage (BC Advantage), where help is available.

If we use the time we have been given for preparation, the transition from ICD-9 to ICD-10 can be very seamless and easy.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient's medical condition(s).

I hope Ive shown you that ICD-10 isnt scary at all. Why do I keep mentioning this? With anything new, we have a fear of the unknown and there are people who use that fear against us. As an example, I received a phone call. Mr. Verno, this is (garbled) with (garbled). Im calling to let you know that we are offering an ICD-10 seminar in your area. If you don't take our seminar, your claims wont be paid. Really? Imagine being a doctor or medical biller being told that the key to your reimbursement is to attend this seminar. Now, lets say you agree to attend at the cost of several hundred dollars, when there, you are told that the key to getting your claims is to buy a wizzwheel for $600. The entire 3 hours is spent giving you small tidbits on ICD-10 but more concentration is on buying the wizzwheel. By the second hour, it is your patriotic duty to buy a wizzwheel. By the third hour, the world will be destroyed by a huge asteroid and there are no astronauts available to

destroy the asteroid and to save the world, you should be buying the whizzwheel! How do I know this? My employer fell for the sales pitch and sent several of us to the seminar. He also bought the wizzwheel which didn't work. The seminar ended and the couple working the seminar left faster than the road runner in those cartoons we know and love. We never saw them again and we couldn't get our money back. They probably went to do another seminar in another town or another local hotel. Well, ICD-10 isnt scary. If you get one of those seminar phone calls, you have the freedom to attend them and if you want to buy a wizzwheel, you can do that too. I will never discourage you from exercising your freedom to make your own decisions. If you wish to attend an ICD-10 seminar, I would recommend taking one from a reliable source such as a recognized coding or billing association. Examples are the American Academy of Professional Coders (AAPC) www.aapc.com, the Professional Association of Healthcare Coding Specialists (PAHCS) www.pahcs.com, the American Health Information Management Association (AHIMA) www.ahima.org   and the Medical Association of Billers (MAB) www.e-medbill.com

Use the following formula: PPD = Lawsuits and/or LOR (Loss of Revenue). (PISS Poor Documentation = Lawsuits and LOR. Again and last, ask, can your documentation save you in a malpractice lawsuit?

If you have questions related to getting ready for ICD-10, I can be reached at steveverno@hotmail.com or sverno@orion-ps.com

I wish all much success and remember my life motto: never give up and never surrender.

Steven M. Verno, CMBSI, CHCSI, CEMCS, CMSCS, CPM-MCS, CHM

<u>References, Helpful Consultants, and Websites</u>
<u>(Listed in no particular order and I receive no renumeration for listing</u>
<u>these companies/people that I trust and recommend):</u>

Medical Association of Billers:
www.e-medbill.com and http://medicalassociationofbillers.yuku.com/

Professional Association of Healthcare Coding Specialists
www.pahcs.org

American Academy of Professional Coders
www.aapc.com

Billing-Coding Advantage (BC Advantage)
www.billing-coding.com

CMS ICD-10 Myths and Facts
https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-
10MythsandFacts.pdf

CMS ICD-10 Implementation Guide for small and medium practices
http://www.sccma-
mcms.org/Portals/19/assets/docs/ICD10SmallandMediumPractices508.pd
f

State ICD-10 Implementation Assistance Handbook
http://www.medicaid.gov/medicaid-chip-program-information/by-
topics/data-and-systems/icd-coding/downloads/icd-10-implementation-
assistance-handbook.pdf

Don Self
www.donself.com

Dr. Jin Zhou
www.erisaclaim.com

Greenbranch Publishing
www.greenbranch.com

American Health Information Management Association
www.ahima.org

Centers for Medicare and Medicaid Services ICD-10
https://www.cms.gov/ICD10/

World Health Organization ICD-10
http://apps.who.int/classifications/apps/icd/icd10online/

American Medical Association ICD-10
http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.shtml

National Uniform Claim Commission
http://www.nucc.org

National Healthcare Leaders Association
www.nhcla.com

Turbocoder
www.turbocoder.net

Orion Portfolio Services
www.orion-ps.com

MNET Financial
www.mnet.com