

# ICD-10 and Gastroenterology



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- ✓ This guide does not contain ANY legal advice.
- ✓ This guide shows what specific codes will change to when ICD-9-CM becomes ICD-10-CM.
- ✓ This guide does NOT discuss ICD-10-PCS.
- ✓ This guide does NOT replace ICD-10-CM coding manuals.
- ✓ This guide simply shows a practice what ICD-10-CM will look like within their specialty. The intent is to show that ICD-10 is not scary and it is not complicated
- ✓ This guide is NOT the final answer to coding issues experienced in a medical practice.
- ✓ This guide does NOT replace proper coding training required by a medical coder and a medical practice.
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For the past thirty-one (31) years, we have learned and used ICD-9-CM when diagnosis coding for our providers . ICD stands for International Classification of Diseases. We've been using the 9<sup>th</sup> Revision to code a documented medical condition. We will be replacing the 9<sup>th</sup> Revision with the 10<sup>th</sup> revision. 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, 2014.***

There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization.

Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the internet for anything that provides provenance to the rumor.

In coding, there is a saying, "If it isn't documented, it doesn't exist." If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. How do I know this? My boss went to a conference and during a break, heard people talking about something. One of the speakers even said the same thing. When my boss came back, he had me stop my work and find out if what he heard was true. After a week of searching, I went back to my boss and told him that what he heard didn't exist. His reply was, I don't believe you. I am a speaker at conferences. Anything I present has laws, rules, or policies provided to show that what I'm saying is true, accurate, and correct.

I personally attended a conference where I heard a speaker say something that didn't sound right. I wasn't the only one because many hands went up. The speaker had many respected certifications, yet the speaker failed to provide any proof to his statement. When I asked for his documentation, he smiled and said "I'll send it to you." Its been 10 years and nothing has come forth. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks. My boss was correct with saying he didn't believe me, but he learned a hard lesson. He spent about \$1,000 in payroll to have me find anything that backed up what he heard at a conference. In the end, he dismissed what

he heard and from that point on, when we brought anything to him, we had to provide documented proof. That made me a better researcher. To provide proof to ICD-10 being effective on October 1, 2014, can be found here:

<http://www.cms.gov/Medicare/Coding/ICD10/Index.html>

October 1, 2014 is on a Wednesday. What this means is, on Tuesday, September 30, 2014, you will use ICD-9-CM. At the end of the day, put your ICD-9 manuals in a safe place because you may need them later on and I will explain this. When you come in the next morning, you will open the brand new ICD-10-CM manuals and code the visit using them.

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn't code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr. Smith with pain in his right ear. All Dr. Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

That code is **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 demands documentation of the anatomical area affected and allows for coding of chronic modalities.**

**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 ear pain in both ears, but all the doctor wrote is "OM" and nothing more. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice.

A favorite doctor I've known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. Many times after looking at the medical record, he recommends writing a check. He provides instruction to medical interns and residents and he tells them: "Document the visit as if you had to appear in court to defend your actions." I usually add, "Document the visit as if your paycheck and career is on the line." I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn't documented, we don't code it. We do NOT code something just to get it paid.

With 30 years of clinical medicine in my personal background, I can say I know what should have been done during the visit, but I can't code based on that. I've seen doctors tell me, "I did this procedure." I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses. I also NEVER code based on what I am told on the internet. I don't know if what I'm told is 100% true, accurate and complete. I don't know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and I NEVER support fraud, including academic fraud, in any form. If I do a coders work for them, they will never learn to become self-sufficient.

Let's say you have an untrained coder who needs to code a cranialrectalectomy. They will go to the internet and ask, "I forgot what the code is for a cranialrectalectomy, can someone help me?" When they don't get a response, they become angry and then they will post, "Can't anyone here help me out?" They do this hoping someone will feel

guilty and give them what they want. Someone may come along with a name of ToddCPC and say we use code 99999. ToddCPC is NOT a coder. ToddCPC is a school kid in Omaha, Nebraska having fun punking the poster. So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they're now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor can't fight this because the claim was sent with wrong codes, codes that are not supported by the medical record documentation.

I recently went to a doctor who received a letter demanding the return of \$64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn't support any correct code that was submitted. Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

## **Coding Guidelines**

**Many of the guidelines under ICD-9-CM wont change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example:**

### **ICD-9 Guideline for Symptoms:**

#### ***Signs and symptoms***

*Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms.*

#### ***7. Conditions that are an integral part of a disease process***

*Signs and symptoms that are integral to the disease process should not be assigned as additional codes.*

### **8. Conditions that are not an integral part of a disease process**

*Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.*

## **ICD-10 Guideline for Symptoms:**

### ***Signs and symptoms***

*Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.*

### **5. Conditions that are an integral part of a disease process**

*Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.*

### **6. Conditions that are not an integral part of a disease process**

*Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.*

**As you can see, both guidelines are virtually identical, so the change to ICD-10 wont be a shock to a trained coder.**

**GASTROENTEROLOGY or Related ICD-10-CM CODING GUIDELINES**  
*(Note, words in bold in the guideline are placed there in the actual guideline.)*

**The occurrence of drug toxicity is classified in ICD-10-CM as follows:**

**Adverse Effect**

Assign the appropriate code for adverse effect (for example, T36.0x5-) when the drug was correctly prescribed and properly administered. Use additional code(s) for all manifestations of adverse effects. Examples of manifestations are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

**Impending or Threatened Condition**

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened."

If the subterms are listed, assign the given code.

If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

**Reporting Same Diagnosis Code More than Once**

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter.

This applies to bilateral conditions **when there are no distinct codes identifying laterality** or two different conditions classified to the same ICD-10-CM diagnosis code.

**Laterality**

For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

**Infectious agents as the cause of diseases classified to other chapters**

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.



## **Infections resistant to antibiotics**

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign code Z16, Infection with drug resistant microorganisms, following the infection code for these cases.

## **Sepsis**

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

### *Sepsis with organ dysfunction*

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction

(MOD), follow the instructions for coding severe sepsis.

(iv) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

## **Severe sepsis**

The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

## **Septic shock**

Septic shock is circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction. For all cases of septic shock, the code for the underlying systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned.

Septic shock indicates the presence of severe sepsis. Code R65.21, Severe sepsis with septic shock, must be assigned if septic shock is documented in the medical record, even if the term severe sepsis is not documented.

### **Sequencing of severe sepsis**

If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission) the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

Severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

### **Sepsis due to a postprocedural infection**

Sepsis resulting from a postprocedural infection is a complication of medical care. For such cases, the postprocedural infection code, such as, T80.2, Infections following infusion, transfusion, and therapeutic injection, T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

### **Sepsis and severe sepsis associated with a noninfectious process (condition)**

In some cases a noninfectious process (condition), such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis, is present a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis it should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis either may be assigned as principal diagnosis.

Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.

*See Section I.C.18. SIRS due to non-infectious process*

## **Chapter 11: Diseases of Digestive System (K00-K94)**

Reserved for future guideline expansion

### **Complications of care**

#### **(a)**

#### **Documentation of complications of care**

As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

## **Chapter 20: External Causes of Morbidity (V01- Y99)**

Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, **and the person's status (e.g., civilian, military)**.

### **General External Cause Coding Guidelines**

#### **1) Used with any code in the range of A00.0-T88.9, Z00-Z99**

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

## **2) External cause code used for length of treatment**

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

## **3) Use the full range of external cause codes**

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, **and if applicable**, the activity of the patient at the time of the event, **and the patient's status**, for all injuries, and other health conditions due to an external cause.

## **4) Assign as many external cause codes as necessary**

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

## **5) The selection of the appropriate external cause code**

The selection of the appropriate external cause code is guided by the Index to External Causes, which is located after the Alphabetical Index to diseases and by Inclusion and Exclusion notes in the Tabular List.

## **6) External cause code can never be a principal diagnosis**

An external cause code can never be a principal (first listed) diagnosis.

## **7) Combination external cause codes**

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

## **8) No external cause code needed in certain circumstances**

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g. T360x1- Poisoning by penicillins, accidental (unintentional)).

## **Selection of Principal Diagnosis**

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

In determining principal diagnosis the coding conventions in the ICD-10-CM, Volumes I and II take precedence over these official coding guidelines.

*(See Section I.A., Conventions for the ICD-10-CM)*

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

#### **A. Codes for symptoms, signs, and ill-defined conditions**

Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

#### **B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.**

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

#### **C. Two or more diagnoses that equally meet the definition for principal diagnosis**

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

#### **D. Two or more comparative or contrasting conditions.**

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

### **E. A symptom(s) followed by contrasting/comparative diagnoses**

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

### **F. Original treatment plan not carried out**

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

### **G. Complications of surgery and other medical care**

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

### **H. Uncertain Diagnosis**

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

**Note:** *This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.*

### **Abnormal findings**

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

**Please note:** *This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.*

### **C. Uncertain Diagnosis**

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

**Note:** *This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.*

## **Diagnostic Coding and Reporting Guidelines for Outpatient Services**

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

### **A. Selection of first-listed condition**

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

## **1. Outpatient Surgery**

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

### **ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit**

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

### **H. Uncertain diagnosis**

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

***Please note:*** This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

### **Chronic diseases**

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

### **J. Code all documented conditions that coexist**

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

### **K. Patients receiving diagnostic services only**

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special



examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

**Please note:** This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

### **NUMERICAL ORDER BY ICD-9-CM**

#### **ICD-9-CM**

**289.50** - Spleen disease NOS

#### **ICD-10-CM**

**D73.9** - Disease of spleen, unspecified

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#### **ICD-9-CM**

**455.0** - Internal hemorrhoids without mention of complication

#### **ICD-10-CM**

**K64.8** - Other hemorrhoids

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#### **ICD-9-CM**

**530.81** - Esophageal reflux, Gastroesophageal reflux

#### **ICD-10-CM**

**K21.0** - Gastro-esophageal reflux disease with esophagitis

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#### **ICD-9-CM**

**530.85** - Barrett's esophagus

#### **ICD-10-CM**

**K22.70** - Barrett's esophagus without dysplasia

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#### **ICD-9-CM**

**531.90** - Gastric ulcer; unspecified as acute or chronic; w/o hemorrhage or perforation; w/o obstruction

#### **ICD-10-CM**

**K25.9** - Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation

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#### **ICD-9-CM**

**533.90** - Peptic ulcer NOS

#### **ICD-10-CM**

**K27.7** - Chronic peptic ulcer, site unsp, w/o hemorrhage or perf

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**ICD-9-CM**

**535.50** - Unspecified gastritis and gastroduodenitis; without mention of hemorrhage

**ICD-10-CM**

**K29.70** - Gastritis, unspecified, without bleeding

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**ICD-9-CM**

**553.3** - Diaphragmatic hernia, Hernia: hiatal (esophageal) (sliding), paraesophageal, Thoracic stomach, Excludes:, congenital: diaphragmatic hernia

**ICD-10-CM**

**K44.0** - Diaphragmatic hernia with obstruction, without gangrene

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**ICD-9-CM**

**V12.72** - Personal history of; colonic polyps

**ICD-10-CM**

**Z86.010** - Personal history of colonic polyps

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**ICD-9-CM**

**V76.51** - Screening for malignant neoplasms; colon

**ICD-10-CM**

**Z12.11** - Encounter for screening for malignant neoplasm of colon

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## Alphabetical Index of Codes by Disease

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Barrett's esophagus

**530.85** – ICD-9-CM

**K22.70** - ICD-10-CM

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Diaphragmatic hernia, Hernia: hiatal (esophageal) (sliding), paraesophageal, Thoracic stomach, Excludes:, congenital: diaphragmatic hernia

**553.3** - ICD-9-CM

**K44.0** – ICD-10-CM

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Esophageal reflux, Gastroesophageal reflux

**530.81** – ICD-9-CM

**K21.0** - ICD-10-CM

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Gastric ulcer; unspecified as acute or chronic; w/o hemorrhage or perforation; w/o obstruction

**531.90** – ICD-9-CM

**K25.9** - ICD-10-CM

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Gastritis, unspecified and gastroduodenitis; without mention of hemorrhage

**535.50** – ICD-9-CM

**K29.70** - ICD-10-CM

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Internal hemorrhoids without mention of complication

**455.0** – ICD-9-CM

**K64.8** - ICD-10-CM

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Peptic ulcer NOS

**533.90** – ICD-9-CM

**K27.7** - ICD-10-CM

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Personal history of colonic polyps

**V12.72** – ICD-9-CM

**Z86.010** – ICD-10-CM

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Screening for malignant neoplasms; colon

**V76.51** – ICD-9-CM

**Z12.11** - ICD-10-CM

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Spleen disease NOS

**289.50** – ICD-9-CM

**D73.9** - ICD-10-CM

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The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented "Chest pain". The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.

**Pain(s)** (see also Painful) R52

- - chest (central) R07.4
- - - anterior wall R07.89
- - - atypical R07.89
- - - ischemic I20.9
- - - musculoskeletal R07.89
- - - non-cardiac R07.89
- - - on breathing R07.1
- - - pleurodynia R07.81
- - - precordial R07.2
- - - wall (anterior) R07.89

As you can see from the above ICD-10 index, you have chest pain listed as R07.4. Next you want to go to the tabular section to make sure that R07.4 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code. The tabular for R07 is on the next page.

- **R07 Pain in throat and chest**
- Excludes.:dysphagia (R13) epidemic myalgia (B33.0) pain in:breast (N64.4)
- neck (M54.2)
- sore throat (acute) NOS (J02.9)
- **R07.0 Pain in throat**
- **R07.1 Chest pain on breathing**
- Incl.:Painful respiration
- **R07.2 Precordial pain**
- **R07.3 Other chest pain**
- Incl.:Anterior chest-wall pain NOS
- **R07.4 Chest pain, unspecified**

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information,

so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you can code ICD-9, you can code ICD-10. If you don't have the training in the process of coding, you won't be able to code under ICD-10.

## **CODING CHAPTERS**

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)
- Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
- Chapter 5: Mental Disorders (290-319)
- Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
- Chapter 7: Diseases of Circulatory System (390-459)
- Chapter 8: Diseases of Respiratory System (460-519)
- Chapter 9: Diseases of Digestive System (520-57)
- Chapter 10: Diseases of Genitourinary System (580-629)
- Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
- Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
- Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
- Chapter 14: Congenital Anomalies (740-759)
- Chapter 15: Newborn (Perinatal) Guidelines (760-779)
- Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
- Chapter 17: Injury and Poisoning (800-999)
- Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

- Chapter 1: Certain infectious and parasitic diseases (A00-B99)
- Chapter 2: Neoplasms (C00-D48)
- Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
- Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
- Chapter 5: Mental and behavioral disorders (F01-F99)
- Chapter 6: Diseases of the nervous system (G00-G99)
- Chapter 7: Diseases of the eye and adnexa (H00-H59)
- Chapter 8: Diseases of the ear and mastoid process (H60-H95)

Chapter 9: Diseases of the circulatory system (I00-I99)  
Chapter 10: Acute upper respiratory infections (J00-J06)  
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)  
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)  
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)  
Chapter 14: Diseases of the genitourinary system (N00-N99)  
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)  
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)  
Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)  
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)  
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)  
Chapter 20: External causes of morbidity (V01-Y98)  
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes  
V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

There were 18 Chapters in ICD-9-CM and we have 20 chapters under ICD-10-CM.

The proposed effective date for ICD-10 is October 1, 2014.

So, what do we have to do?

## **PREPARING FOR ICD-10**

### **Training**

If your current coder has NO training, you need to send them to be trained how to code. If they cannot code under ICD-9, they will not be able to code under ICD-10. As I stated the process of coding is the same. Being the spouse of the doctor, a receptionist or an accountant is NOT a coder. A coder MUST read the medical record, go to the coding manual and find the code in the Index, then go to the tabular and read the actual code. The coder must read any coding conventions to determine the exact code that is documented in the medical record. Coding is NOT getting a test study guide and taking that test to be awarded initials. What happens is that the person comes along and asks for codes using the internet. Its sad when you see

someone with reputable coding initials asking basic questions, "Can someone give me a code for chest pain?" or what code can I use with a cranialrectalectomy? The code being provided may be fake and the person asking will have no clue on this because they don't know how to code and they won't open the manual. Forums will stop providing codes to those who ask. Right now, some are telling the person asking for a code that the forum is not the proper place to ask for codes. The student who cheats by asking a forum to provide them with the coding answers to their homework or their test will find themselves expelled and if hired, will become unemployed.

At one time, I was teaching a coding class. I gave my students a homework assignment. One of my students asked every question, hoping to get someone to do her work. Someone gave her all incorrect answers. When she turned in her homework, the class was given a pop quiz. The pop quiz was the homework assignment. She made a copy of her homework and tried to hide the pages in her coding manual. Instead of looking up the codes, she was copying the answers from her homework. She was very surprised that she failed every test answer. What was also interesting is that a couple of my other students did the same thing by going on the internet to get someone to answer their homework assignment. It was interesting that the student had every homework question correct, yet, they failed the same identical question when tested on those questions.

Years ago, I was taught RTFM! When I asked a fellow coder a question, his reply was RTFM! Over and over I was told RTFM! What's RTFM? READ THE FREAKING MANUAL, only freaking is a nice way of saying the "F" word. They were right. I must have read thousands of medical records during my training and my coding book was so worn out. I learned: Read the medical record, look up the condition in the index, look up the code in the tabular, pay attention to coding conventions. I spent 6 months on a probationary status before being allowed to code an actual visit for claim submission. My teacher made sure I was 100% accurate, 100% of the time.

In a company where I worked, we had a coder with a mile of initials come to me, asking, Steve, "What code can I use with this?" I smiled and gave her wrong codes because I had no clue how to code at the time. The boss called her to ask her where she got her information. She said Steve gave them to me. When I was asked, I said, "I'm not a coder and yes, I gave them to her, but it's her job to code, not mine." She was terminated. My punishment was to undergo coding training and my teacher could make a seasoned Marine Corps drill sergeant cry. Today, many practices now give a coding employee candidate a pre-employment test. These tests don't come with a study guide. You are given the test cold, without advance notice and you better pass. Having initials after your name won't allow you any special privileges. I recently spoke to one doctor. She told me if you walk in with initials after your name, turn around and leave. You won't be hired. When I ask why, she told me, "Steve, these people are supposed to know how to code, but they can't do it, they don't know what they're

doing”, so she makes her job easy. Initials don’t get hired automatically. If you fail her coding test, she contacted your coding association with the recommendation that your initials be revoked and she will tell that association that under no circumstances will any of their coders be hired by her or her associates, simply because she doesn’t trust the certification that the organization issues.

To repeat myself, if you know how to code using ICD-9, you should have no problem coding using ICD-10. If not, take this time to undergo training. A doctor’s spouse, a receptionist, medical biller and accountant is NOT a coder. A biller is trained in the basics of coding to understand the codes to be placed on the claim and a medical biller uses their basic knowledge of coding to appeal a claim denial when coding is involved, but a medical biller is not a coder.

Staff coders with training and certification need to undergo ICD-10 familiarization training to show coding using ICD-10 codes are not going to be difficult. If you can code under ICD-9, you shouldn’t have any problems coding under ICD-10. American Academy of Professional Coders (AAPC) will need to undergo a proficiency assessment for certification. Professional Association of Healthcare Coding Specialists (PAHCS) certified coders do not. So, if your coder is certified by the AAPC, ensure that they take the AAPC ICD-10 proficiency assessment so that they can undergo recertification.

### **Documentation:**

If your documentation is currently insufficient or poor, now is the time to improve your documentation. Include anatomy if the condition affects an anatomical area. If there is right or left or both, document left or right or both. Take your ego down a step and look at how important your documentation affects many. If affects YOU as a doctor, it affects your staff who depend on the claims payment to be paid themselves. It affects your patient. Your lack or insufficient documentation could result in improper or insufficient treatment, causing you to undergo a malpractice lawsuit. Sadly many malpractice lawsuits are settled out of court due to poor documentation and many more are lost in court. Your documentation or lack thereof will determine if you will win or lose the lawsuit.

As a patient, I’ve looked at the records of my visits. The doctor who doesn’t document properly loses me as their patient. The doctor that cannot document my visit properly, places my health in jeopardy. When I’m asked by friends or family members who they should see for their healthcare, the doctor who poorly documents will not get my recommendation. You have 10 months to improve your documentation. Again, if it isn’t documented, it doesn’t exist and you don’t code it.



Look at the following documentation and ask yourself, can you code from it and is it complete?

S: Pt here for follow up  
O: Pt improving since last visit.  
A: Doing much better  
P: RTC in 2 weeks.

OK, what do we have? Nothing! Pt here for follow up, follow up for what? When was the patient seen last and why. What medical condition is being treated for, during this visit? Doing much better is not a diagnosis. I'm sure you can agree that the documentation above is very poor, but, you would be amazed at how often this happens. Someone will go on the internet and ask, my doctor treated a patient, can someone give me a code so I can get the visit paid? Ok, what code would YOU select? I'd take this back to the doctor and have a heart to heart with him/her.

Here is another:

S: Pt here with c/o vision problems in both eyes.  
O: Snellen test: 20/15. PERL  
A: Deep Cataracts in both eyes.  
P: Referral to Dr X, ophthalmologist.

Really? Cataracts with pupils equal and reactive to light? 20/15 vision with cataracts? This doctor charged a 99215 office visit. There is nothing within this documentation that supports a 99215 established patient office visit. The doctor contacted me because he was wondering why the insurance company requested many of his patient's medical records and now they wanted \$64,000 returned to them.

OK, here is one more:

S: Pt here C/O pain in large right toe after stubbing toe on coffee table.  
O: Large (R) toe red & painful to touch. All systems are reviewed and are negative.  
A: (1) Aids (2) Sprain toe (3) Strain Toe (4) Fx Toe, (5) Lumbago  
P: Referral to Dr. Y (Orthopedist)

Again, Really? This was a 99214 visit. AIDs? Where is the lab test and why is there a diagnosis of AIDs with a toe pain complaint? How can there be a diagnosis of a fracture with no xrays. It looks like someone is trying to cover all bases. There is nothing documented to show us that this patient is a returning patient. There is NO xray, NO lab, so, again, where did the doctor use to determine Aids and a fracture? Not only that, the patient has a sprain, strain AND a fracture of the same body part? This whole thing screams badly! Where did the back pain come from? Why were all body

systems examined and if there is back pain, what is causing it? The patient stubbed their toe. If all systems are negative how is it there is back pain in addition to the toe problem? Is this a fishing expedition to justify a high level office visit? When asked, the doctor said he was told to do this by the insurance company. Naturally they denied the doctor's accusation. The insurance company is the entity auditing the doctor and demanding the return of past payments.

Now, how does the following look:

S: 57 Y/O obese male C/O chest pain x 20 minutes. Chest pain began while pt was sitting in a chair on a cruise ship that was headed to shore. Pain suddenly and without warning radiated across center of chest and down the left arm to the fingers. Pain felt like heartburn. Pt denies sweating and breathing difficulties. Pt took baby aspirin to alleviate the pain. Pain was a 5 on a scale of 10 and then started disappearing approximately a few moments after taking baby aspirin. When the ship docked, pt debarked and drove self to emergency room with no increase in chest pain during the drive. There was no LOC, dizziness or any other symptoms. pt has no known personal history of cardiac problems. Has never suffered from high blood pressure or any other cardiac problems. Grandfather suffered heart attack at age 67. Grandfather passed away due to heart attack. Father passed away at age 57 from prostate cancer. Mother is also deceased. She passed away in 2010 at age 77 from lung cancer. Both parents were heavy smokers. Father was also an alcoholic. Pt has no known allergies and is taking no other medications. This is pts first chest pain episode. Pt decided to go on a no carbohydrate diet about 3 months ago to lose weight. This was not physician recommended or supervised. Pt only ate meats, eggs, and cheeses for all three meals. Pt doesn't drink alcohol or smoke. Pt does not exercise at all. Pt is 355 lbs and appears morbidly obese.

O: Skin is warm and dry to touch. No evidence of cyanosis on lips or fingers. There is no pain upon abduction and adduction of both arms. Pt shows equal strength in both hands and is able to walk heel to toe with no pain or problems. Will order cardiac enzyme tests and an EKG. Reviewed medical records and there are no entries suggesting that pt has had this medical condition in the past. Blood Pressure: 160/110 Pulse 120 Respirations 32. Pt does not appear to be in distress, is aware of time and place. PERL. EKG shows tachycardia and nothing else. Cardiac enzymes are elevated suggesting cardiac event. Contacted pts primary care physician. Last visit with PCP was 2 years ago for flu like complaints. No flu like complaints at this time. No medications prescribed. No complaints similar to current complaints made to PCP during any past visit. Contacted Dr Hart, staff cardiologist who recommends admission, tests for possible heart blockage, Rx of blood thinners, and MRI of heart. Chest pain, Hypertension, Tachycardia, CHF and morbid obesity.

A: Chest pain, Hypertension, Tachycardia, CHF and morbid obesity.

P: Heparin, 80 units/kg IV bolus, Referral to Dr Hart in Cardiology, Admission to coronary intensive care unit.

A little better? This was billed as a 99285 emergency care visit and it is clearly supported by the excellent documentation. Again, put aside all egos and make sure you are improving your documentation. How would you want your visit documented if you were the patient? Document as if you had to go to court! As a coder, I can tell you that I've won many appeals just because the doctor documented the visit in an outstanding manner. The documentation was key when being reviewed by a regulatory agency. Documentation can make the difference between getting a claim paid, a denial overturned with a payment in the hundreds of dollars versus writing a refund check for thousands of dollars.

### **Manuals**

ICD-10 Manuals will need to be obtained and used. Don't get rid of your ICD-9 manuals. Why? Lets say, Steve comes to see you on Tuesday, September 30, 2014. Steve's visit is under ICD-9-CM coding. Due to some unknown reason, Steve is shown as uninsured or self pay even though Steve provided his insurance coverage when he was seen. You send Steve multiple statements instead of sending a claim. Steve thinks that this is nothing more than an administrative error on your part and you will fix this and send a claim to his health plan, but the problem isn't fixed. Steve's account is eventually sent to a debt collection agency. After this happens, you are contacted by regulatory agencies, Steve's insurance and Steve's lawyer. It might be possible that a claim can still be sent to Steve's health plan so that it is not denied as timely filing. It could now be 2015 and the codes used in 2015 are ICD-10 codes, but Steve's visit is supposed to be coded using ICD-9, simply because ICD-10 wasn't effective on the day Steve was seen. If you send the claim using ICD-10, the claim will be denied because the codes you selected were not effective. Now, could this happen? Very possibly because I've seen it happen many times.

In 2004, I worked for a doctor. He retired in 2004, closing his practice. In 2010, we received a court order to send a claim to a patient's insurance company. We originally sent a claim and it was denied, causing us to bill the patient. The patient took his health plan to court. The fact that the insurance company was ordered to pay the claim, didn't stop them from trying to avoid doing so. As an attempt to not comply with a court order, they demanded a replacement claim citing the reason that due to the timeframe, all claims from 2004 were purged from their computer system and they didn't have the original claim anymore to process it. Their thinking was, if the provider couldn't send a replacement claim, there was nothing to process and then no need to pay it. They could inform the judge that they couldn't process and pay what they didn't have, but that didn't work.

What they didn't realize is that when the doctor retired, we exported all of his software files and placed them on a storage drive we kept in a bank safe deposit box, so recreating the claim wasn't too hard, but we had to ensure that the 2004 codes were on the resubmitted claim. I extracted the original claim data, verified the accuracy and manually produced a claim form which was sent to the insurance company, the patient's lawyer and the judge. We also ensured we had a signed authorization from the patient allowing us to send the claim to his lawyer and judge so that we stayed within HIPAA privacy requirements. The insurance company received the claim and decided to see if they could continue to throw up roadblocks to keep from complying with the court order. Now they demanded the medical record with the thinking that there was no way that the medical record would be available after all these years, but they were wrong. Again, all medical records were scanned and stored electronically on the storage drive. The record was found, reprinted and sent to the insurance company. With no more roadblocks, they had the claim and the medical record, so they complied with the court order and paid the claim.

So, don't throw those ICD-9 books away, put them in a safe place in the event you need them. A 1 terabyte harddrive costs around \$89 and you would be amazed at how much data it can hold. I go back to 1999 with the doctor's data and we have claims, EOBs, checks, correspondence, checks, and medical records with room to spare. We used a simple \$49 all in one printer, scanner, fax machine, so saving data is not expensive these days.

### **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, 2013 proposed effective date, Claims for September 30<sup>th</sup> and before September 30<sup>th</sup> dates of service will still use ICD-9 Codes. Your software will need to be able to handle both code sets. If not, then you will need to replace all ICD-9 codes with ICD-10 codes. You will also need to add additional ICD-10 codes for the medical conditions that could not be coded under ICD-9. As you saw above, some medical conditions may have ONE ICD-9 code but could have many under ICD-10, especially those codes that rely on anatomical areas. You want someone trusted to make your software changes to ICD-10 codes and you want to verify that their work is 100% true, accurate, and correct.

### **Updated Carrier Policies and Procedures**

Providers who are contracted and have agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes. 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. While YOU may be ready, are they? Will your claims be bogged down by claims from doctors who are not ready? ABC Insurance Company may have a policy for a cardiac stress test. In that policy, there are diagnosis codes that support medical necessity. If Steve

comes in for his annual cardiac stress test and the code under ABC's policy is R07.4 (chest pain), you want to ensure that Steve's medical record documents R07.4 so that you can comply with the coding requirement for the cardiac stress test. If you have code L21.0, you can bet the claim will be denied for medical necessity. Why? I don't think a diagnosis of dandruff supports a cardiac stress test, do you? Again, if you agreed to comply with an insurance policy, you want to make sure you have a copy of the updated policy to ensure compliance with that policy. Go to your local Medicare MAC and download their LCDs for the services you render. Go to your local Medicaid carrier to also download those policies that affect the medical care you provide. You don't want to find yourself behind the 8 ball when the changeover takes place. Staying on top of these things will keep your practice revenue ongoing.

### **Updated Compliance Plans**

Practices and Billing Companies should update their compliance plans regarding ICD-10 coding. Extra attention should be directed to performing internal audits of charts and claims. You want to catch any problems early so that they don't become worse, which could cause carrier or investigative agency audits which may come with fines, penalties, loss of licensure, sanctions and closure. When you do what is right, you have no fear of audits or inspections. You welcome them.

### **Updated Coding Denial Appeals**

If you are using a cookie cutter appeal, then the appeals should be reviewed and updated to conform to ICD-10 standards. If you are appealing a denial of an EKG, you can't have ICD-9 code 786.50 as the code for chest pain, if the documentation has chest pain, you have to change the code to R07.9 or R07.4 (the final code hasn't been published yet and depending on the source, you could find either code listed)

### **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). Many superbills I've looked at, have the correct diagnosis identified by name, but the ICD-9 code is incorrect or outdated from the current ICD-9 code. On one, the diagnosis is identified as HIV. The code shown on the superbill is 042.59. HIV is 042 only. Under ICD-10, HIV is B20.

It may take a few weeks to convert all your ICD-9 codes on a superbill, then send it to your printing company for publishing. If you do this now, you won't be pressured into trying to get it done in a few days just to have it available on October 1, 2014.

### **FINANCE:**

There are practices that are in excellent financial shape. There are practices that can barely make it from day to day. You have 10 months to work on a financial plan that can allow you to survive this change. While you may send a claim on October 1, it doesn't mean that the claim will be paid quickly. There may be delays. Insurance

companies process billions of claims every day, so you can imagine what happens when millions of unprepared doctors are sending claims at the same time and those claims are slowing down the insurance company's processing time. While YOU may be ready, they might not. Their system may have a hiccup causing your claims to be pended while they request medical records from you.

Make sure you are financially secure until the system is in full force where you are getting payment within reasonable timeframes. You worked hard to make your practice successful, keep working to keeping it going. Not only do you depend on your claim revenue, so does your entire staff. Bills will continue to come in and they will still demand payment regardless if your claims are paid or not.

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". You are NEVER under the radar. Insurance companies already know what codes you bill and what codes you should be billing. Finding more codes available could lead to temptation to upcode or to submit a false claim to increase practice revenue.

If we use the time we have been given for preparation, the transition from ICD-9 to ICD-10 can be very seamless. Procrastination may work for filing an IRS tax return. This doesn't work in our profession. You need to be prepared well enough in advance so that you are ready to go when you come in to treat patients on Wednesday morning of October 1<sup>st</sup>. I've said it so many times, ICD-10 is not scary to a trained coder. I've been looking at it for many years. If I can code ICD-10, so can you and I'm 61 years old!

Be very careful because any time something is new, someone will want to make money on it. You may receive phone calls, faxes and letters telling you that a seminar on ICD-10 is available. Some calls may be pressure calls which sounds like, "Hello, this is (garbled) with (garbled). We're offering training on ICD-10. If you don't attend this seminar, your claims wont be paid." They are very good at making you believe that you need to attend their seminar and when you show up, you are under several hours of expert sales tactics to buy books that they are selling. I know I've been to them. I would recommend that if you wish to attend a seminar, you do so through a trusted organization such as the Medical Association of Billers (MAB), the Professional Association of Healthcare Coding Specialists (PAHCS), the American Academy of Professional Coders (AAPC) or an organization that you trust completely, however, we live in the land of the free, and you have the freedom of choice to attend any seminar you wish and I wont try to dissuade you from doing so. There is an old saying which goes, Caveat Emptor.

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).

Use the following formula: PPD = Lawsuits and LOR (Loss of Revenue). (PPD stands for PISS Poor Documentation = Lawsuits and LOR.

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That is steve\_verno.

I wish all much success and  
Never Give Up, Never Surrender!

Steven M. Verno