ICD-10 and Podiatry

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Disclaimer:

- **I am not a lawyer; I'm a coder and Medical Biller.**
- **I do not provide legal advice and I never answer "Is it or is this Legal" questions.**
- **I am not an approving authority and this guide is NOT an authoritative reference.**
- **I do not say it is OK to do something, especially something that may be perceived that may be illegal, immoral, or unethical.**
- **I do not provide private consulting services, private research, or private investigational services.**
- **I do not referee office bets or office disagreements.**
- **I do not answer personal questions.**
- **I do not testify in court.**
- **I provide guidance and information for training purposes only.**

The information in this guide came from ICD-10 sources available for free on the internet at the CMS or World Health Organization website.

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The codes in this guide were obtained from the US Department of Health and Human Services, NCHS website.
This guide does NOT discuss ICD-10-PCS.
This guide does NOT replace ICD-10-CM coding manuals or is to be used as a cheat sheet for coding.
This guide simply shows a practice what ICD-10-CM will look like within their specialty, so that the practice can see that ICD-10 is NOT scary or overly complex.
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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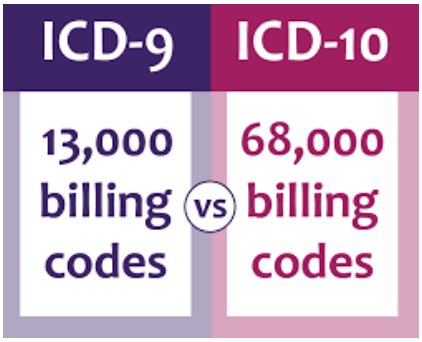
Introduction:
For the past thirty-one (31) years, we have learned and used ICD-9-CM when assigning diagnosis codes for our providers. ICD stands for International Classification of Diseases and we've been using the 9th Revision to code a documented medical condition. ICD-9 assigns a number representing a diagnosis to explain why the patient came to us for medical care. ICD-9 supports the medical care that is provided to a patient. As an example, if I went to a podiatrist with an infected toe and the podiatrist performed an ingrown toenail removal which is CPT code 11730. Using an ICD-9 code of 786.50 (chest pain) would not support the reason why the ingrown toenail was removed and the insurance company will request further information (or deny it) regarding the claim you sent. I'm sure you will agree that a diagnosis of 703.0 (ingrown nail) would support the nail removal. That is the simplicity of coding.

We will be replacing the ICD- 9th revision with the ICD-10 revision. The reason why we are moving to ICD-10 is because ICD-9 is old and many medical conditions do not have a code assigned to it because none are available. When coding for emergency room visits, it is frustrating trying to find a diagnosis code that doesn't exist or trying to find a code that matches what the doctor documented.

ICD-10 would open the flood gates and allow the assignment of a code to a disease or injury.



As the world becomes smaller due to the ease of moving around our world, diseases that did not exist in a geographical area may be found in that area. If you remember the recent EBOLA scare, this shows how someone could contract a disease in Africa and it is brought to the United States. We've seen space accidents with the Challenger disaster and with terrorism coming to our cities, these accidents and incidents need to have a code assigned to them when we treat the patient. As our world becomes smaller and as technologies improve or are invented, we need to assign diagnosis codes to

cover the illnesses and injuries that require treatment. Insurance companies wont pay a medical claim without the appropriate and medically necessary diagnosis.

ICD-10 will replace ICD-9-CM as of October 1, 2015.

There is a rumor and belief by many that ICD-10 will be bypassed and we will go straight to ICD-11. The reason why this rumor is believed by many is because of all of the delays we've seen with the effective date for ICD-10 and from some of the more public objections to implementing it.

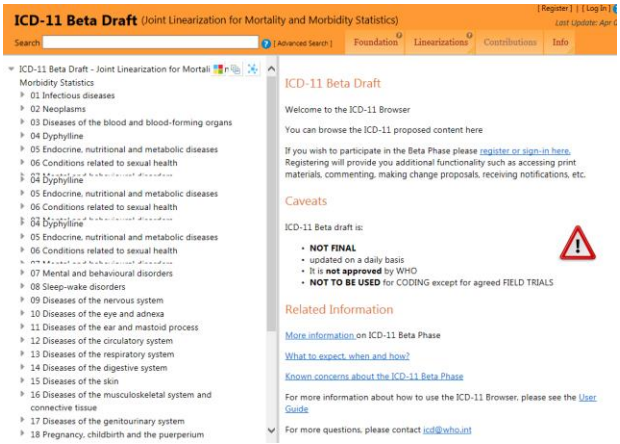
At first the effective date went from 2013 to 2014 and 2014 to 2015 and now there is a bill before congress to make another change. The bill has not made it out of Congress, so, it isn't a law or the final word. These constant changes allow someone to question what will actually happen and the problem with this new rumor is that there is nothing in writing from any official source. You may have someone who constantly comes to you and says, "I heard or someone told me that ICD-10 won't happen", "I went to a conference and someone said that ICD-11 will be the new code set for diagnosis coding", or "I got a phone call telling me that I need to attend their seminar to be ready for ICD-11 and if I don't attend their seminar, my claims won't be paid!".

I've been to some of those conferences and heard things that didn't sound right and the person who said what didn't sound right had a ton of reliable credentials, but, they had nothing to prove what they said. This person sounds impressive and you want to believe what they are telling you, but you don't have time to try and validate what you were told. I want to see proof with something such as a change. The Health Insurance Portability and Accountability Act (HIPAA), a Federal Law, mandates that the Centers for Medicare and Medicaid Services (CMS) manages the code sets that we use for visits and diagnosis coding. When CMS announces any changes, it is usually posted on their website, www.cms.gov and it is usually published in the Federal Register.

The following is a screen capture of the CMS, ICD-10 website:

You can see that CMS has a countdown clock to when ICD-10 becomes effective. That is in 175 days from today, April 8, 2015. There is nothing that says ICD-10 will be bypassed and replaced with ICD-11, therefore when someone tells me that ICD-10 won't happen or that it will be bypassed by ICD-11, I see nothing that supports that from the official source so I have to do what should be done so that when the clock reaches zero, my doctors and I will be ready for ICD-10.

If you go to the ICD-11 website, http://apps.who.int/classifications/icd11/browse/l-m/en you will see the following:



The ICD-11 website shows nothing to say that it will bypass ICD-10 and that it will be the official code set for diagnosis coding this year or in 2017. If you wish to believe that ICD-10 won't happen or if ICD-10 will be bypassed for ICD-11, you are free to do so but, until there is official information on the CMS website and the Federal Register, I, personally will continue with the current data that ICD-10 will take place on October 1, 2015. If you wish to download the Federal Register publication, you can go to https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-18347.pdf

When you look at the October 2015 calendar, you can see that October 1st is on a Thursday. This means that you will code the visits for Wednesday, September 30, 2015 using ICD-9 codes. When you go home that Wednesday, put your ICD-9 coding books away (DO NOT THROW THEM AWAY!) and when you come to work and start coding for October 1, 2015 dates of service, you will need to use your ICD-10 books for that date of service.

Why don't you want to throw you ICD-9 books away? Let's say I came to see your doctor on Wednesday, September 30th to have my ingrown toenail removed. Somehow, I am entered into your system as an uninsured or self-pay patient. When I receive your billing statement in October, I may dismiss it as an administrative accident or think that this is a statement that tells me what my visit costs while my insurance company is processing the claim you sent to them. In November 2015, I receive a second statement, so I call your office to remind you that I provided you with my insurance information. Again, somehow this fell into a crack and I get a statement in December 2015. I look at it as another mistake and believe that this will be fixed. It is now March 2016, I get a bill from your debt collection company, MNET Financial. I write to MNET to dispute the debt I inform MNET that I have insurance to pay for this visit

which is Medicare and United Healthcare (these are examples only, not my real insurance) and I provided that information to the doctor's office not once but twice. Medicare has a one year time limit to send a claim, so March 2016 is within that time limit, so it is possible to send a claim to Medicare without it being denied for timeliness. My state law, specifically FS 627.6131 states that a claim must be sent to my secondary insurance (United) within 90 days from the date of payment of my primary insurance, so once Medicare pays the claim, it is still timely to send a claim to my secondary insurance without being denied for timeliness, but, that doesn't mean my secondary won't deny for timeliness, but that is appealable using my State law.

If you wish to learn more about appealing a claim denial, you can contact me through the organization or association that provided you with this guide so that a webinar can be scheduled. The date of service is September 30, 2015, but, the current date is March 2016, you can't use ICD-10 codes for the claim for September 30, 2015 because ICD-10 wasn't effective on September 30th.

CMS published Medical Learning Matters (MLN) SE 1239. You can download this by going to
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1239.pdf

In this document, CMS states the following:

Important, please be aware:

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.

When you send the claim to Medicare, in March 2016 for date of service of September 30, 2015, you will need to send it with ICD-9 codes, NOT ICD-10 codes. The CPT code will be the code identified in the 2015 CPT manual which is 11730 for the ingrown toenail removal. The diagnosis code will be 703.0 and not L60.0 for ingrown nail.

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-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was very forgiving to a doctor who is lax on their

documentation. Steve could visit Dr. Smith with pain in his right ear. When Dr. Smith documented 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. Some specialties such as podiatry is anatomically oriented, so documenting anatomical areas shouldn't be a surprise for Podiatric providers.

To give you an idea how Otitis Media looks when coded using ICD-10-CM, you have the following codes:

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. Under ICD-9, there is a possibility for even more codes for Otitis Media, but the documentation of the disease by the doctor limited the ability to select a more define code. ICD-10 will demand better documentation.

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. The best common sense advice I can give providers is: "Document the visit as if you and the medical record had to appear in court. Ask yourself, will the medical record document survive a malpractice lawsuit? Can it protect your wallet, your reputation and your career as a medical provider?". That one lawsuit due to poor documentation could grow to many possible lawsuits and possible sanctions and loss of medical license. I've seen

where doctors have had their medical license placed on probation due to poor medical record documentation. As a patient, I've successfully disputed upcoded medical bills. I have no reservation with paying a correct medical bill.

I work with patients when they come to me asking me if the medical bill is correct. I'm not a lawyer, but, if I can find problems with your documentation, can a lawyer who is skilled with the letter of the law find the same problems or (possibly) others? I'm sure that the lawyer will bring these problems before a judge or jury. Will your medical malpractice insurance company go to court to fight or will they simply write a check to settle the lawsuit? Take a close look at your current documentation. Look at any requests for medical records. Look at your practice revenue and see if you have a significant loss and look at claim payment refund demands. Put your ego aside and see if your documentation needs improvement. If you are either getting 1) medical record requests by lawyers, insurance companies and patients, 2) if you see a significant reduction in practice revenue, 3) if you have an unusually large amount of claims that have gone unpaid, 4) your insurance accounts receivables has grown, or 5) insurance companies are demanding the return of claims payments based on their audit of your claims, then you may have a problem with your medical record documentation which could be causing these problems.

I code correctly to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. Using simple common sense, I follow a simple coding rule I established for myself:

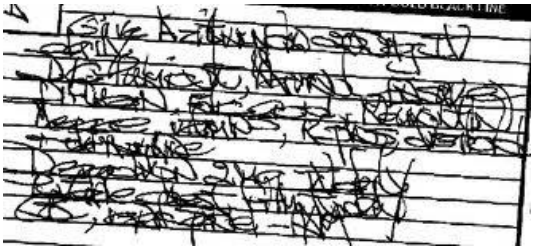
If it isn't documented, I don't code it.

This simple personal rule/mantra has protected me for many years and it will stand the test of time. With 20 years of clinical medicine in my personal background, and as a patient, I have an excellent idea of what should have been done during the visit, but I cannot code based on that. For example, if I have chest pain and I go to a doctor, because I have both a personal and family history of cardiac medical conditions, it is common sense to perform an EKG to determine if my chest pain is due to a heart attack, but if the EKG and results are not documented, I cannot say that an EKG was performed. It should have been done, it might have been done, but there is nothing in writing that shows it was in fact done. So without it being documented, there is no proof and I cannot code for it. Now I have had 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 out.

If you go to court, the medical record will most likely be entered as evidence. While on the stand, a good lawyer will probably ask the following:

Lawyer: “Doctor, tell us what you did to Mr. Verno when he came to see you on (date)”.
Doctor: “I did an EKG, a head to toe exam and I checked his pulses and distal sensation in both legs.”
Lawyer: “Did you listen to his chest and if so what did you find?”
Doctor: “Yes, I listened to his chest and the sounds were normal.”
Lawyer: “What did the EKG results tell you?”
Doctor: “His EKG was normal.”
Lawyer: “Doctor, please look at peoples exhibit 222, the medical record for the 1/12/2014 visit. Where does it say you did a head to toe exam?”
Doctor: “It’s here somewhere, I cannot find it, but I know I did it and I swear that I did it.”
Lawyer: “Doctor, where does it say you did an exam at all?”
Doctor: “I did it, I always do a head to toe exam on every patient.”
Lawyer: “Doctor, please read the text highlighted in yellow.”
Doctor: “Patient here for follow-up, doing well. Instructed to return in 2 weeks. Sending letter to PCP, thanking PCP for sending Mr. Verno to me for treatment.”
Lawyer: “Doctor, does it say you did a head to toe exam? Does it say you listened to his chest? Does it say you performed an EKG? Doctor, you do know Mr. Verno came to you with severe chest pain and died an hour after leaving your practice?”

Oops. You do know that this conversation with a doctor in court never took place. Is it far-fetched to ask if this could this happen? Could this happen to you?



After presenting the medical record above the cross-examination may go further:
Lawyer: “Doctor, is this the medical record for Mr. Verno?”
Doctor: “Yes it is!”
Lawyer: “You testified that you performed an EKG on Mr. Verno. Can you show the court where it documents that you performed an EKG on Mr. Verno? Can you see the EKG?”

Do you agree that this documentation needs improvement?

When I'm asked, what code can I use with this CPT code? I never provide an answer even when pressured by the person asking the question. As a coder, I never code based on what I am asked on the internet. Firstly, I don't know if what I'm told is 100% true, accurate and complete. Secondly, I don't know anything about the person asking and whether the person asking the question works for a doctor, if they are a coding student or if they are a patient doing their own personal investigation. Thirdly, I don't know their motive for asking.

My personal policy is to NEVER help students. If I provide them with answers, they may submit my work as their own. When they do this, they may be committing academic fraud, and I NEVER support fraud, including academic fraud, in any form. Also 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 something like, "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 "Coder Rick" and say we use code 99999. They don't know that "Coder Rick" is NOT a coder. Here, "Coder Rick" is a fake person used to present a point. Now "Coder Rick" could be a school kid in Omaha, Nebraska having fun punking the poster or be a 58 year old trucker on a break in Des Moines, Iowa having fun seeing what could happen. Who knows? "Coder Rick" could be the instructor in the students' coding class and is providing a false answer to see if the student submits that answer as their homework assignment or test answer!

So, now the coder follows "Coder Rick's" advice and enters 99999 as the code and sends the claim to the insurance company which of course, denies payment. Surprised? The coder may be working for a chiropractor and asks for a code for Vax D Therapy. "Coder Rick" says to use code 64772. Code 64772 is surgical decompression of one or more nerves.

In 2006, two chiropractors were sentenced to 34 years in Federal prison for billing and collecting from Blue Cross and Blue Shield more than $2 Million. Now Vax D Therapy is considered experimental and investigational by most health plans, including Medicare. While you have the freedom of choice to use code 64772, it is not advisable because of the consequences. The correct code for Vax D therapy is S9090 and if you sent the claim using S9090, it will be denied, but the doctor, coder or biller wants to get the claim paid, so they're looking for a code that will not get the claim denied.

As a provider, you are responsible for all claims sent under your name. You find claim after claim is denied payment because untrained coders submit claims with bad codes. Now you begin to notice the volume of denials and a huge drop in your practice revenue and you are getting a large volume of letters demanding copies of the medical records. In addition, other insurance companies put all your claims on hold pending an investigation. These letters are demanding medical records going back 20 years! An investigation for possible fraud can go back 20 years? Are those 20 years of medical records documentation 100% true, accurate and complete? If not, you don't need to be a mind reader to know the results of the investigation. Be prepared to get a demand for the refund of many claims payments and a possible subpoena to appear before a medical board at the State or Federal level. The code 64772 on the claim is wrong and it is not documented in the medical record. It will be difficult to 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 him how his coder/biller was sending claims with wrong codes and that the medical record documentation was so poor, that they didn't support any correct code that was submitted. Remember my personal rule/mantra DOCUMENT THE MEDICAL RECORD AS IF THE RECORD WAS YOUR DEFENSE IN A MALPRACTICE LAWSUIT? Well the doctor appealed the refund demand and lost those appeals. Why? The medical record did not support what he billed to the insurance company. He did not refund the overpayments, so the insurance company took the money back from claims he submitted, so now he had no income for several months. Now when other insurance companies hear about this situation with the doctor they may get in the queue and start to do the same. With no income, the doctor cannot pay his staff, and as a result the staff quit and may hire a lawyer to sue him for their paychecks. His patients leave and go to other doctors. This is a classic example of Newtons' laws of motion or as some would say he was up the "You know what" creek without a paddle.

Conduct routine audits of your claims and documentation. Some doctors have huge egos and don't like to be told anything so, I ask that if you are this type of doctor put your ego aside while I provide you with some free advice. Prevention costs little as compared to court costs, attorney fees, refunding payments, loss of your medical license, closure of your practice and sanctions for at least 5 years. As a consultant, I charge a considerable sum for my time and guidance. My father once told me that it's not just who you know, it's what you know that makes you money. You can make money using a hammer but you can make more money knowing how and where to use the hammer.

As a patient myself, I see the mistakes made by doctors who treat me and when I see a mistake, I am not silent and I don't give up until the mistake is corrected. I like my personal doctors and I want them around to continue to treat me. OK, now I'm off my soapbox, so let us continue with ICD-10 and my goal is to show you that ICD-10 isn't scary and that the conversion to ICD-10 is not going to cause the world to end.

I've been looking at ICD-10 for several years and it's like finding an old favorite tattered sweater in the bottom of your shirt drawer. If you are not scared of ICD-9, you will not be scared of ICD-10 and I am about to show you ICD-10.

Coding Guidelines

Many of the guidelines under ICD-9-CM will not change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example of guidelines that will look familiar to you:

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 won't be a shock to a trained coder.

Coding Guidelines for Podiatry

The following are some ICD-10 coding guidelines that may impact Podiatry providers. Please note that these are not ALL of the ICD-10 guidelines, just a sample, and, again, these look identical to ICD-9 guidelines. These guidelines are published by the World Health Organization:

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.

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.

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.

Multiple coding for a single condition
In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. "Use additional code" notes are found in the Tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same

as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

“Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

Acute and Chronic Conditions
If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

a. Site and laterality
Most of the codes have site and laterality designations. The site represents either the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a “multiple sites” code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

Bone versus joint
For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

Acute traumatic versus chronic or recurrent musculoskeletal conditions
Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

Osteoporosis
Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

Osteoporosis without pathological fracture
Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.31, Personal history of osteoporosis fracture, should follow the code from M81.

Late Effects (Sequela)
A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

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.

Coding of Injuries
When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-10-CM, but should not be assigned unless information for a more specific code is not available. These **traumatic injury** codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

Primary injury with damage to nerves/blood vessels
When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

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

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.

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.

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.

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.

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.

External cause code can never be a principal diagnosis

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

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.

Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause.

Unknown or Undetermined Intent Guideline
If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

Late Effects of External Cause Guidelines

Late effect external cause codes
Late effects are reported using the external cause code with the 7th character extension "S" for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

Late effect external cause code with a related current injury
A late effect external cause code should never be used with a related current nature of injury code.

Use of late effect external cause codes for subsequent visits
Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

External cause status
A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event. A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

History (of)
There are two types of history Z codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history Z code categories are:

- Z80 Family history of primary malignant neoplasm
- Z81 Family history of mental and behavioral disorders
- Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
- Z83 Family history of other specific disorders
- Z84 Family history of other conditions
- Z85 Personal history of malignant neoplasm
- Z86 Personal history of certain other diseases
- Z87 Personal history of other diseases and conditions
- Z91.4- Personal history of psychological trauma, not elsewhere classified
- Z91.5 Personal history of self-harm
- Z91.8- Other specified personal risk factors, not elsewhere classified
- Z92 Personal history of medical treatment

Except: Z92.0, Personal history of contraception
Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Screening
Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases
Z12 Encounter for screening for malignant neoplasms
Z13 Encounter for screening for other diseases and disorders
Except: Z13.9, Encounter for screening, unspecified
Z36 Encounter for antenatal screening for mother

Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases. **Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.**

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. Should a patient receive multiple types of antineoplastic therapy during the same encounter, code Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes **depends on the circumstances of the encounter.**

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae**. F**or others, the condition is **included** in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare Z category/codes:

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices
Z47 Orthopedic aftercare
Z48 Encounter for other postprocedural aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare

Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with 7th character “D,” that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain **multiple** visits. Should a condition be found to have recurred on the follow-up visit, then the code for the condition should be assigned as an additional diagnosis.

The follow-up Z code categories:

Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z39 Encounter for maternal postpartum care and examination

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.

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.

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.

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.

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.

Previous conditions
If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. 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.

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.

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.

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.

Accurate reporting of ICD-10-CM diagnosis codes
For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

Encounters for circumstances other than a disease or injury
ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

Level of Detail in Coding

ICD-10-CM codes with 3, 4, or 5 digits
ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth fifth digits, sixth or seventh digits which provide greater specificity.

Use of full number of digits required for a code
A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character extension, if applicable.

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.

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)

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.

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.

Patients receiving therapeutic services only
For patients receiving therapeutic 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.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

Podiatry Diagnosis Codes

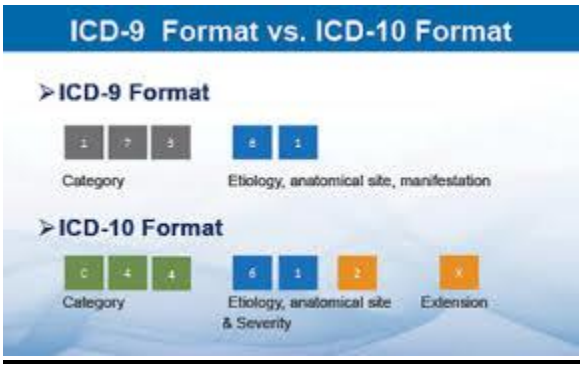
The following are some of the most used codes in some Podiatric practices. Please understand that this guide does NOT contain all codes used. This guide does not take the place of coding or published coding manuals. This is NOT a coding cheat sheet. This guide is NOT to be used to assign a diagnostic code to a service. *WE DO NOT AND WE NEVER CODE ASSIGNING A CODE TO A SERVICE!!!*

This guide is to show you what the codes you use will look like when ICD-10 takes place on October 1, 2015. I am also trying to show you that ICD-10 is not as scary as some may wish you to believe. (I know I'm repeating myself, but I learned that we remember things when it is repeated to us). I've received phone calls telling me that I need to attend their seminar if I want my claims paid by the insurance companies. I see these as scare tactics and they don't know that I know better.

Let me tell you a secret, CMS, the World Health Organization or any other State or Federal regulatory organization has NOT published any documents that mandate that you or your staff attend an ICD-10 seminar in order that your claims are paid! If you wish to attend a seminar of your choice, you are free to do so! Me? I want to obtain my information from trusted and reliable sources. I trust The Medical Association of Billers (MAB), the Professional Association of Healthcare Coding Specialists (PAHCS), the National Healthcare Leaders Association (NHCLA), The Healthcare Billing and Management Association (HBMA) and the Centers for Medicare and Medicaid Services (CMS). The organizations or associations that you trust may differ and if I did not mention those you trust, I may not know them or have interacted with them.

The ICD-10-CM codes listed in this guide are current as of the day this guide was prepared. If additional information is needed to obtain a more accurate code, it will be noted. Some ICD-9-CM codes do NOT convert easily to ICD-10-CM. The medical record documentation will need to be more specific.

ICD-9 codes are 3, 4, or 5 numbers with E or V codes being a letter and a set of numbers, up to 5 digits. ICD-10 is a letter and numbers. It can go up to 7 digits. Code I06.8 is not one zero six point eight. It is letter eye zero six point eight. V70.0 is an ICD-9 code, not an ICD-10 code.



When you look at the following, you see the common Podiatric medical conditions, what the correct ICD-9-CM diagnosis code looks like and what the same medical condition looks like when it becomes an ICD-10-CM code. Where did I get these medical conditions? Easy! They were obtained from a podiatric practice superbill which treated me for an ingrown toenail.

You may be asking where can I get superbills? The internet is full of data if you know where to look. You can go to the Don Self website at www.donself.com. He has tons of superbills and information that you can use to improve yourself and your practice. Don is one of a handful of people I trust completely. I also get superbills from doctors who treat me. The Podiatry superbill came from the podiatrist who treated my ingrown toenail. I look at the superbills and try to see the most common diagnoses on all of them and place the common ones here.

The easiest place to find ICD-10 codes is the 2015 ICD-10-CM manual. I've seen it and it is huge! If you have an android device like a smart phone, tablet or Kindle, you can go to the Google store and download a free ICD-10 app. I also use software called Turbocoder. You can learn more about it at www.turbocoder.net. This program allows me to do a quick search for CPT, ICD-9, and HCPCS codes. When you find the ICD-9 code, they took this a step further and also display the ICD-10 code for the disease. When I code, I don't rely completely on software, I go old school. I read the medical record to see what is documented and I open the coding books to verify the correct code(s), read the coding conventions, guidelines and the code definition. I verify that the code I am selecting is 100% true, accurate, and correct. I know that I sound like I'm

on a soapbox, preaching, but, I want to see that you code that way you should be coding.

Unfortunately, practices are hiring employees with NO training in coding or billing. These untrained employees are making critical mistakes and it is affecting patients. You can be sure that the insurance company is also noticing your mistakes and will choose to ask that they want the payment(s) back NOW! I don't know any doctor that can afford to lose patients or to place their practice in jeopardy.

There is an old law in sales and business. It is called Gerard's Law of 250. What this means is for every one person you interact with, you interact with 250 other people. That patient you ignored and terminated, could interact with at least 250 other patients and in today's world of the internet and social media that 250 could be 2,500 or 25,000 before you know it.

My primary care provider told me that I needed to have a colonoscopy done again as it has now been 5 years since my last one. Later that day, the receptionist called me to tell me that she contacted Doctor X who will call me to schedule a consult appointment. When I heard the name of Doctor X, I told the receptionist that I refused to see Doctor X, when she asked why, I told her it was because of his improper coding, billing and lack of patient communication. I emailed a friend of mine who lives in Chicago where he works for a national practice who does colonoscopies. I asked him for the name of one of their local doctors and he recommended Doctor Y. I called my PCP and told him I wanted to see Doctor Y. I also knew Doctor Y when he was a resident at a hospital I worked at 43 years ago. Doctor X moved his practice to a medical office across the street from Doctor Y. When I went to see Doctor Y, his parking lot was full of cars and there was only one car parked in front of Doctor X. Doctor X's office has called my phone almost every day to have me schedule an appointment for the "consult". When I went in to see Doctor Y, he looked at me and said I know you, you look familiar to me. It could be that he has a good memory or it was the pictures of me on the FBIs 10 most wanted list and a recent episode of COPS. So, it seems Girard's law of 250 still works and may be affecting Doctor X.

Again, I want you to succeed when ICD-10 gets here in a few months. Think of October 1, 2015 as a reset button on your coding and billing practices. You will spend the next several weeks looking for things that you may not be doing correctly and fixing them. When you come to work on Thursday, October 1st, you will not see California sinking into the ocean, the White House being destroyed by a wall of water and the air craft carrier, John F. Kennedy. It will be the start of a new day and the start to a better practice.

NUMERICAL ORDER BY ICD-9-CM

ICD-9-CM
078.12 Plantar wart

ICD-10-CM
B07.0 Plantar wart

ICD-9-CM
110.01 Onychomycosis

ICD-10-CM
B35.1 Tinea unguium

ICD-9-CM
682.7 – Cellulitis of foot

ICD-10-CM
L03.119 - Cellulitis of unspecified part of limb

L03.129 Acute lymphangitis of unspecified part of limb

ICD-9-CM
700 Corns and callosities

ICD-10-CM
L84 Corns and callosities

ICD-9-CM
703.0 Ingrowing Nail

ICD-10-CM
L60.0 Ingrowing nail

ICD-9-CM
726.71 Achilles bursitis or tendinitis

ICD-10-CM
M76.60 Achilles tendinitis, unspecified leg

M76.61 Achilles tendinitis, right leg

M76.62 Achilles tendinitis, left leg

ICD-9-CM
726.73 Calcaneal Spur

ICD-10-CM
M77.30 Calcaneal spur, unspecified foot

M77.31 Calcaneal spur, right foot

M77.32 Calcaneal spur, left foot

ICD-9-CM
727.1 Bunion

ICD-10-CM
M20.10 Hallux valgus (acquired), unspecified foot

M20.11 Hallux valgus (acquired), right foot

M20.12 Hallux valgus (acquired), left foot

ICD-9-CM
733.00 Osteoporosis, unspecified

ICD-10-CM

M81.0 Age-related osteoporosis without current pathological fracture

M81.6 Localized osteoporosis [Lequesne]

M81.8 Other osteoporosis without current pathological fracture

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ICD-9-CM
734 Flat Foot

ICD-10-CM
M21.40 - Flat foot [pes planus] (acquired), unspecified foot

M21.41 - Flat foot [pes planus] (acquired), right foot

M21.42 - Flat foot [pes planus] (acquired), left foot

ICD-9-CM
735.5 Claw Toe

ICD-10-CM
M20.5X9 Other deformities of toe(s) (acquired), unspecified foot

M20.5X1 Other deformities of toe(s) (acquired), right foot

M20.5X2 Other deformities of toe(s) (acquired), left foot

ICD-9-CM

754.61 Congenital Flat Foot

ICD-10-CM

Q66.50 Congenital pes planus (pes planus congenital flat foot congenital rigid flat**)**

Q66.51 Congenital pes planus, right foot

Q66.52 Congenital pes planus, left foot

ICD-9-CM

782.3 – Edema

ICD-10-CM

R60.0 – Localized Edema

R60.1 – Generalized Edema

R60.9 – Edema, Unspecified

ICD-9-CM

895.0 Amputation, Traumatic of toe(s) (complete) (partial) without mention of complication

ICD-10-CM

S98.119A Complete traumatic amputation of unspecified great toe, initial encounter

S98.129A Partial traumatic amputation of unspecified great toe, initial encounter

S98.139A Complete traumatic amputation of one unspecified lesser toe, initial encounter

S98.149A Partial traumatic amputation of one unspecified lesser toe, initial encounter

S98.219A Complete traumatic amputation of two or more unspecifed lesser toes, initial encounter

S98.229A Partial traumatic amputation of two or more unspecifed lesser toes, initial encounter

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One thing that ICD-10 is showing you is that the one ICD-9 code can become several ICD-10 codes and with Podiatry, anatomy is critical to coding correctly.

The Coding Process

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 ICD-10 codes are identified in bold print. The coding conventions are not bold. If you are familiar with the ICD-9 coding conventions, they look familiar to you in ICD-10. The red printing identifies the correct code and it's description. That is what I did for easy identification.

The tabular for R07 is below.

- **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 effective date for ICD-10 is October 1, 2015.

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. It's 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? Remember the example I gave you ebfore with “Coder Rick”? To the untrained person, the answer looks legitimate but it may be completely wrong. Forums will stop providing codes to those who ask. Right now, some associations are telling the person asking for a code that the forum is not the proper place to ask for codes and on some websites the answer isn’t provided at all which causes the person looking for a code to use intimidation such as I thought I could come here and the professionals would help a colleague who asks for help. The student who cheats by asking a forum to provide them with the coding answers to their homework or their test could find themselves expelled and if hired, will become unemployed.

I recently met the owner of a local medical practice. She had no problem telling me that when someone walks in, seeking employment and they have initials after their name, she won’t hire them. When I asked why, her answer was simple: Steve, they can’t do what they’re supposed to do and I don’t trust their certification. As I stated, I see someone asking a basic coding question and that person supposedly has impeccable coding certification initials after their name. To be very honest, I expect this coder to be providing the answer versus asking the question.

At one time, I was teaching a coding class. I gave my students a homework assignment. One of my students went onto the internet and asked every question that was on her assignment, hoping to get someone to do her work. Someone gave her all incorrect answers. When she turned in her homework, I gave the class 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. She appealed the failure accusing me of not teaching her what was on the test. I had to appear before a board to answer the student’s accusations. I showed that I DID teach the material, I also showed how she was absent for the training. I also showed the homework assignment and the student’s answers to the homework assignment, the test taken by the student and her answers to the test and I provided a screen print of the website where she asked the questions and the answers that were provided and that her answers were identical to what was on the website. Amazingly, she had used her real name on the website to obtain the answers. She was expelled for academic fraud. 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. Coding isn’t rocket science and the process of coding isn’t difficult, but to succeed at coding, you need to learn how to code. Picking up a brick doesn’t mean you can build a house. Using a calculator doesn’t make you an accountant. Playing a flying game on a PS3 doesn’t make you a pilot.

The American Academy of Professional Coders (AAPC) certified members will need to undergo ICD-10 retesting for certification. Professional Association of Healthcare Coding Specialists (PAHCS) certified coders do not. PAHCS has been looking at ICD-10 and they see that ICD-10 isn’t scary and if you can code ICD-9, you can code ICD-

10. So, if your coder is certified by the AAPC, ensure that they take the AAPC ICD-10 test 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.

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? Where is the date of service? Where is the history, Examination and Medical Decision making? What medical condition is being treated 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. Someone may ask, “We just saw a patient and we always bill a 99245 consult, what diagnosis can I use to get the 99245 paid?” Is the above documentation for a 99245 consultation? Does the documentation follow the CPT guidelines for a consultation? Again, do we have the three key components documented for a 99245 visit? You will be amazed at how some will say yes to all of these questions and then they wonder why they’re getting refund demands and medical record requests.

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, opthalmologist.

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 (3) Fx Toe, (4) 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 x-rays? It looks like someone is trying to cover all bases with this visit. There is nothing documented to show us that this patient is a returning patient. There is NO x-ray, 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 NO! Also, 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 the insurance company 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 aspiring 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, causing his demise at age 67. Father suffered a heart attack at age 53 but survived. 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 was instructed by a medical provider at ABC Clinic 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 355lbs and is 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 date, time and place. PERL. EKG shows tachycardia and atrial fibrillation. Cardiac enzymes are elevated suggesting cardiac event. Contacted pts primary care physician, Dr. X. Last visit with PCP was 2 years ago for flu like complaints. No flu like complaints at this time. Patient is taking no medications. No complaints similar to current complaints made to PCP during any past visit. Contacted Dr Hart, staff cardiologist, by phone who recommends admission, cardiac catheterization, and IV of heparin. Dr. Hart is on the way to hospital to see patient and assume care thereof.

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

P: Heparin, 80 units/kg IV bolus, Admission to coronary intensive care unit to follow coronary care protocols.

How's that? A little better? Also, understand that this is a fictional patient and visit. I am not a cardiologist, so be gentle if what I wrote is not what a cardiologist would do. My purpose is to show how documentation can be improved to justify what is being coded and billed. This was billed as a 99285 emergency care visit and it is clearly supported by the documentation of the three key components and the coding guidelines for an emergency care visit. 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 every visit as if you were the defendant in a medical malpractice lawsuit! 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 and making a decision that favored the doctor. Documentation can get a claim paid, a denial overturned with a payment in the hundreds of dollars versus writing a refund check for thousands of dollars. Your documentation is your paycheck, the

paycheck for your staff and allows your patient to pay the correct medical bill versus an upcoded medical bill. In some states, upcoding may result in the doctor losing their medical license**.**

Manuals

ICD-10 Manuals will need to be obtained and used. Don't get rid of your ICD-9 manuals. Why? Think of that patient who came to you on Wednesday, September 30, 2015. If it is possible to send a claim that is within all documented claim submission time limits, then send it with the CPT and ICD-9 code sets for that date of service.

I do AR recovery work to try and get correctly coded claims paid that haven't been paid and were originally sent within all applicable time limits. Medicare, Tricare and Medicaid have a one year time limit. Providers who have signed a contract with a commercial insurance company may have anywhere from 30, 60, and 90 days. An ERISA Health plan may have up to 2 years. Look at your State law, here in Florida, we have FS 627.6131 and 641.3155, 627 for commercial claims, 641 is for HMO claims. Both State insurance laws have a 6 month time limit and that 6 months starts from the date of service or from when you receive the correct insurance information. The patient may have been seen on 9/30/2015 and it is now 6/15/2016, if I, as the biller for the provider, just received the correct insurance information, then, to me, I am still within that 6 month timeframe, but I still need to use the manuals for 9/30/2015 and submit the claim using ICD-9. So, don't throw those ICD-9 books away, put them in a safe place in the event you need them. However, whenever you code, you need to use the current code set for that date of service.

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. Your software will need to be able to handle both code sets. If you print a CMS 1500 form using version 0812, it has been changed to reflect more codes to be placed in Block 21 and in Block 21, you need to identify the codes as ICD-9 using a 9 or ICD-10 using a zero (0). If you cannot automatically upload the ICD-10 code set, then you will need to add 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. I will recommend that you add ICD-10 codes based on disease description vs ICD-9 codes because someone may have entered your ICD-9 codes incorrectly or you have an ICD-9 code that is deleted or changed. Someone may have been adding codes who had no training as a coder, so when they saw HIV, which is code 042, they may have felt that 042 needed to be a 5 digit code versus a three digit code. So when they entered HIV as a diagnosis, they

entered 042.99. They may have gone to the internet and asked, “Can someone give me the code for HIV?” “Coder Rick” may come back and say use 042.99 and they did. When you wish to add HIV as an ICD-10 code, look up HIV and you will see that it becomes B20, if you try to look up the code 042.99, you will have problems. As an example, a practice wanted to know why their claims were being denied. The doctor was using codes that were deleted 7 years ago. His coders were not using current manuals. All it took to fix this was to get current coding manuals and update his billing software with current ICD-9 codes.

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 R07.9 (chest pain), you want to ensure that Steve’s medical record supports the code R07.9 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 always become aware of situations which may cause fraud, abuse or waste. 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 an updated to conform to ICD-10 standards. If you are appealing a denial of an EKG for a date of service after October 1, 2016, 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.

I wish to add that a cookie cutter appeal is a tool used to guide you, every appeal is different so you need to change every appeal to match the circumstance behind the visit, the insurance company, and the denial.

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 seen 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 or a few months 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 will not be pressured into trying to get it done in a few days just to have it available on October 1, 2015. Oh, and that one page superbill may become 3, 4, or 5 pages long because as you have seen there are medical conditions which may have many ICD-10 codes and you need to make sure each anatomical area is listed such as left foot, right foot or both feet.

FINANCE:

There are practices that are in excellent financial shape. There are practices that can barely make it from day to day. You have less than 6 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 company's 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. The best way to stay under the radar is to do everything correct before you send a claim.

POST OCTOBER 1, 2015

This is when you are going to be vulnerable and this is when you will be very busy.

You may be sending claim after claim and many are going unpaid because of delays. The claim may have been sent with ICD-9 codes or the wrong ICD-10 codes. The insurance company may have requested records and your staff sent those records. When you call the insurance company be prepared to be told, we never received them. Make sure it is done by Certified Mail/return receipt. This is to provide proof of submission and receipt.

While at an insurance company, I had claims that were in the office of the nurse reviewer. When I met her and asked her why my claims were still in her office, she replied, I never received a response to my medical record request. I pulled out my flash drive and showed her that the records were sent and received, to an including the date it was received. Her assistant's signature was on the document. She replied that she never received them. No problem, I told her I was headed to their CEOs office and I'm calling the practice attorney. Before I made it to the elevator, she stopped me and said her assistant took the medical records home with her. I just looked at her and said I'll see you in your CEOs office, and I'm still calling our attorney. She asked me to delay this. The assistant arrived with the medical record and the nurse released the claim for immediate payment.

You need to maintain a constant eye on your claims, record requests, and appeals. This timeframe for AR recovery is vital to your success. The longer you wait on a claim, the older it becomes and then it dies. I work AR every day, starting fresh on Mondays. I spend the week working on the unpaid claims, requests for information is answered immediately and, again, sent by certified mail.

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 but 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 Thursday morning of October 1st. 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 62 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. These folks can sell ice cubes to polar bears. 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, the Professional Association of Healthcare Coding Specialists, the American Academy of Professional Coders 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 won't 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.

I can be reached at steveverno@hotmail.com

I wish each of you much success and I leave you with my life philosophy of
Never Give Up, Never Surrender!

Steven M. Verno

Helpful Websites

Billing-Coding Advantage	http://www.billing-coding.com
Centers for Medicare and Medicaid Services:	www.cms.gov
Don Self:	www.donself.com
PAHCS:	www.pahcs.org
Medical Association of Billers:	www.e-medbill.com
MAB Medical Billing Forum:	http://medicalassociationofbillers.yuku.com/
National Healthcare Leaders Association:	www.nhcla.org
Turbocoder:	www.turbocoder.net
World Health Organization ICD-11:	http://apps.who.int/classifications/icd11/browse/l-m/en

About Steve Verno

Steve Verno is a Certified Medical Billing Specialist Instructor, a Certified Healthcare Coding Specialist Instructor, a Certified Emergency Medicine Coding Specialist, a Certified Multi-specialty Coding Specialist, a Certified Practice Manager-Medical Coding Specialist, and a Certified Healthcare Manager. His specialties include emergency medicine, family practice, internal medicine, pediatrics, Medical Accounts Receivables Recovery, Insurance Claim Resolution, ICD-10-CM, and ERISA.

Steve was also active with the American Red Cross as a lifeguard, Water Safety Instructor, CPR Instructor Trainer, First Aid Instructor Trainer, AIDs Instructor and Home Nursing Instructor. While in Oklahoma, he was a Captain of the Comanche County Disaster Team. He also attended the American Red Cross College in Massachusetts becoming an Instructor Trainer in Health and Safety Services. Steve's entry into coding and billing didn't arrive until he was 40 years old. He underwent training to become a medical coder and biller and eventually becoming an instructor in coding and billing.

Steve contributes monthly articles to BC Advantage magazine, PAHCS and the MAB newsletters. Steve, in concert with Don Self co-authored the book, "The Medical Office Guide to ERISA" which is published by Greenbranch publishing. To assist practices with the upcoming change to ICD-10, Steve has created specialty guidebooks for Emergency medicine, Oncology, Internal Medicine, Chiropractice care, surgery, family practice, cardiology, gastroenterology, sports medicine, ophthalmology and radiation oncology. More guidebooks are being prepared to help guide many specialties to learning that ICD-10 isnt as scary as some would like you to believe and to be ready for the transition seamlessly.