ICD-10: 4 Weeks Out – Are You Ready?

Kathy Mills Chang, MCS-P, CCPC

Our Plan for Today

• Your ICD-10 Action Plan: Getting Started
• Map Your Codes: ICD-9 to ICD-10 the Easy Way
• Find the Codes: FAST!
• Important Terminology and Anatomy for the Whole Team
• Documentation Requirements in ICD-10
• Master the Tabular List for Pinpoint Accuracy
• Make Your Case: Real World Practice with Real Case Studies

ICD-10 Delay

Start Here: What’s ICD-10?

The WHO and the Why

Why Do We Need ICD-10?

Today’s state needs are dramatically different than they were 30 years ago when ICD-9 was introduced. ICD-10 will advance healthcare in many ways, with benefits accruing to quality measurement, public health, monitoring, and performance, and health IT advances.
What Have YOU Done So Far?

- Determine and designate the team member who will serve as your ICD-10 Project Manager.
- Ask the mailing list for the ICD-10 Industry Email Updates list by clicking here (http://www.cms.gov/Medicare/Coding-BCGICD-10/ICD-10-Industry-Email-Updates.html).
- Create an ICD-10 Transition e-mail and/or paper file system to serve as a repository for all your ICD-10 training and transition materials.
- At this point, your software should have been updated to Version 5010 for electronic transactions. If not, do so now.
- Contact your practice management software vendor and find out their plans and timelines for ICD-10 transition.
- Contact your electronic health record software vendor and find out their plans and timelines for ICD-10 transition.
- Make a list of and/or gather together all contacts throughout your office and in third-party vendors, create a plan to contact each group to find out their plans and timelines for ICD-10 transition.
- Based on your findings so far, update and revise your transition budget for ICD-10. Be sure you have allowed for additional doctor and staff training, software updates, coding guide purchases, and other expenses associated with transition.
- Confirm that your Medicare Administrative Carrier (MAC) has updated the Local Coverage Determination (LCD) for chiropractic. It should contain the ICD-10 codes and coding guidelines for billing Medicare. Print this out and review it in a meeting. Schedule a consultation with MACs on an on-going basis to review new codes and how these new codes will affect your practice.
- Ensure that your software can handle both ICD-9 and ICD-10 codes as necessary, as it’s possible that Personal Injury and Workers’ Compensation claims will carry ICD-10 to the same time frame as other carriers.
- Continue contributing to your recommended savings plan to protect your practice. In case there are disruptions to the revenue cycle due to delays, plan payments during the last quarter of 2015. Identify the carriers you need to contact about ICD-10 coding.
- Review and download new payer Medicare/HCFA policy from the website containing updates for ICD-10. Pay close attention to the codes used most frequently in your practice. Make necessary changes to documentation and coding practices to comply with the updated ICD-10 policy.

Testing Anyone?

- Begin testing claims
- CMS has a process
- Check with each additional carrier
- When do they accept testing?

Who’s In Charge?

- Have you selected an ICD-10 project manager?
- Someone must coordinate and ensure all the steps get done
- What gets measured gets managed!

Can We Just Crosswalk from ICD-9?

- General Equivalence Mappings (GEMs)
- Some pointing based on the initial set up
- Three possible ways to define subluxation: M99.01, M99.11, or S13.11
- Now we know
One-to-one Mapping

723.1 Cervicalgia → 723.1 Cervicalgia

M54.2 Cervicalgia → M54.2 Cervicalgia

One-to-Five Mapping

• 724.4 Thoracic or lumbosacral neuritis (radicular syndrome of the lower limbs)
  • ICD-10 – M54.14, M54.15, M54.16, M54.17, M54.18 Radiculopathy

M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
M54.18 Radiculopathy, sacral and sacrococcygeal region

Confirmation Required

M62.83 Muscle spasm
  • M62.830 Muscle spasm of back
  • M62.831 Charley horse
  • M62.832 Muscle spasm of calf
  • M62.838 Other specified disorders of muscle
  • M62.89 Other specified disorders of muscle
  • M62.899 Muscle (sheath) hernia
M62 Other disorders of muscle
  • M62.9 Disorder of muscle, unspecified

Conversion Tools

Conversion Tools

Medicare’s GEM Guide
GEMS FAQ

Why do we need the GEMs?
We need the GEMs because:
- ICD-10 is much more specific.
- For diagnosis, there were 14,507 ICD-9-CM codes and 98,832 ICD-10-CM codes.
- For procedures, there were 3,492 ICD-9-CM codes and 7,104 ICD-10-PCS codes in the 2016 versions of ICD-9-CM, ICD-10-CM, and ICD-10-PCS.

Is there a one-to-one match between ICD-9-CM and ICD-10?
No, there is not a one-to-one match between ICD-9-CM and ICD-10, and the reasons for such include:
- There are new concepts in ICD-10 that are not present in ICD-9-CM.
- For a small number of codes, there are no matching codes in the ICD-9-CM.
- There may be multiple ICD-9-CM codes for a single ICD-10 code.
- There may be multiple ICD-10 codes for a single ICD-9-CM code.

Are there instances when it is not necessary to use the GEMs?
The following instances may not be necessary to use the GEMs:
- When a small number of ICD-9-CM codes are being converted to ICD-10-CM and ICD-10-PCS codes, it may be quicker, easier, and more accurate to simply look up the code in an ICD-10-CM or ICD-10-PCS codebook.
- When ICD-10-PCS is implemented on October 1, 2015, coders will use coding books or encoder systems to code rather than using the GEMs.

Exercise: Write down your 20-30 most commonly used codes

Combination Mapping

724.3 Sciatica

- 724.3 Sciatica

M54.30 Sciatica, unspecified side
M54.31 Sciatica, right side
M54.32 Sciatica, left side
M54.40 Sciatica with lumbago, unspecified
M54.41 Sciatica with lumbago, right side
M54.42 Sciatica with lumbago, left side

Let’s Review

ICD-10: The Magic 7th Digit
A, D or S??

ICD-9 to ICD-10 Mapping Tool
Common Chiropractic Codes List

NOW AVAILABLE!

The KMC University
ICD-9 to ICD-10 Mapping Tool
Special Seminar Pricing!

Available here or at KMCUniversity.com
Why the 7th Digit?

• Most categories in chapter 19 have seventh character extensions
• Required for each applicable code, and most categories have three extensions
• A, Initial encounter
• D, Subsequent encounter
• S, Sequela

What’s an Encounter?

In regards to an encounter, the guideline states: "This character ‘D’ subsequent encounter is used for encounters after the patient has received active treatment for the condition and is receiving routine care for the condition during the healing or recovery phases. Therefore, once the provider concludes treatment and is considering the patient as healed or recovered, this character ‘S’ should be used. At that time, the provider should communicate this change in the patient’s condition to the payer, by dropping the seventh character ‘A’ and replacing it with the character ‘D’ or that diagnosis code.

A vs. D

FACT: The revised ICD-10 CM 2015 Official Guidelines for Chapter 19 Injury codes (page 66) states, “While the patient may be seen by a new or different provider, the course of treatment for an injury is based on whether the patient is undergoing active treatment and not whether the provider is replacing the provider for the first time. The character ‘D’ initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: evaluation and continuing treatment by the same or a different physician.”

So sayeth ACA, Chiro Code, and KMC University

Spinal Subluxation

ICD-9 | ICD-10
--- | ---
847.0 | 847.1
813.4xx | 823.3xx
Sprain of ligaments of cervical spine ** $ |
Sprain of ligaments of thoracic spine ** $ |
Sprain of joints and ligaments of other part of neck ** $ |
Sprain of other specified parts of thorax ** $ |
Strain of muscle, fascia, and tendon at neck level ** $ |
Strain of muscle or tendon of thorax ** $
### What Does Mac Daddy Medicare Say?

**Sprain and Strain Codes:**
- **Initial encounter only?**
- **Subsequent encounters listed as part of initial encounter**
- Noridian, National Gov’t Services, and others ONLY list the **A**
- **A** seems to be for “active treatment only”

### Could the “D” Be Appropriate?
- **What about the rehab phase of care?**
- **What if the patient was referred out and came back to finish treatment?**
- **What if the patient returned for an exacerbation?**

### Would the “S” Ever Be Appropriate?
- Extension S, sequela of “late effects”
- Complications or conditions that arise as a direct result of an injury, such as scar formation after a burn
- The scars are sequela of the burn
- When using extension S, use both the injury code that precipitated the sequela and the code for the sequela itself
- The S is added only to the injury code, not the sequela code
- Sequence the sequela first, then injury code
Key Takeaways

- This information is NOT final
- Clarity will come as we inch closer to implementation...or after implementation
- Follow Medicare guidance using “A”
- Stay Tuned!

ICD-10 Excludes Notes

Who’s In and Who’s Out?

So What is “Excludes 1” or “Excludes 2”? 

- Similar to Correct Coding Initiative Edits for CPT Codes
- Dictates when certain codes can be used together and when not
- The explanation will be helpful in the long run

What’s the Difference?

- **Excludes 1**
  A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE.” An Excludes 1 note indicates that the code excluded should not be used at the same time as the code above the Excludes 1 note. The patient may have conditions at the same time. When an Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

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

The Technical Explanation

The difference between Excludes 1 and Excludes 2 codes is important to understand in order to choose the appropriate code for a patient's condition.

Read the Instructions!
723.1 Cervicalgia = M54.2

M54.2 - Cervicalgia
Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.-)

M50-M54 Excludes1: current injury - see injury of spine by body region disfig NOS (M46.4-)

847.0 = S13.4XXX

S13.4XXA - Sprain of ligaments of cervical spine, initial encounter
Sprain of atlanto-axial ligament, cervical
Sprain of atlanto-axial joint
Sprain of atlanto-occipital joint
Whiplash injury of cervical spine

S13 Includes:
- avulsion of joint or ligament at neck level
- laceration of cartilage, joint or ligament at neck level
- sprain of cartilage, joint or ligament at neck level
- traumatic hematoma of joint or ligament at neck level
- traumatic rupture of joint or ligament at neck level
- traumatic subluxation of joint or ligament at neck level

S13.4
- Sprain of anterior longitudinal ligament, cervical
- Sprain of atlanto-axial joint
- Sprain of atlanto-occipital joint
- Whiplash injury of cervical spine

S13 Includes:
- avulsion of joint or ligament at neck level
- laceration of cartilage, joint or ligament at neck level
- sprain of cartilage, joint or ligament at neck level
- traumatic hematoma of joint or ligament at neck level
- traumatic rupture of joint or ligament at neck level
- traumatic subluxation of joint or ligament at neck level

S13 Excludes:
- any associated open wound

S13 Excludes2:
- strain of muscle or tendon at neck level (S16.1)
- The appropriate 7th character is to be added to each code from category S13

847.2 = S33.5XXX

S33.5XXA - Sprain of ligaments of lumbar spine, initial encounter

S33 Includes:
- avulsion of joint or ligament of lumbar spine and pelvis
- laceration of cartilage, joint or ligament of lumbar spine and pelvis
- sprain of cartilage, joint or ligament of lumbar spine and pelvis
- traumatic hematoma of joint or ligament of lumbar spine and pelvis
- traumatic rupture of joint or ligament of lumbar spine and pelvis
- traumatic subluxation of joint or ligament of lumbar spine and pelvis

S33 Excludes:
- traumatic rupture or displacement of lumbar intervertebral disc NOS (M57.4-
- discoloration and sprain of joints and ligaments of hip (S73.3)
- strain of muscle of lower back and pelvis (L39.01)

S33 Excludes2:
- nontraumatic rupture or displacement of lumbar intervertebral disc NOS (M57.4-

872.1 Cervicalgia = M54.2

Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.-)

M50-M54 Excludes1: current injury - see injury of spine by body region disfig NOS (M46.4-)

724.4 - Lumbosacral IVD, w/Radiculopathy

M50 Cervical disc disorders

More Significant than Cervicalgia Alone

Click to view/hide add'l coding info...

Notes:
- code to the most superior level of disorder
- includes cervicography and disc disorders with cervical radiculitic disc disorders

Code(s) Description
M50.00 - M50.03 M50.0 Cervical disc disorder with myelopathy
M50.10 - M50.13 M50.1 Cervical disc disorder with radiculopathy
M50.20 - M50.23 M50.2 Other cervical disc displacement
M50.30 - M50.33 M50.3 Other cervical disc degeneration
M50.80 - M50.83 M50.8 Other cervical disc disorders
M50.90 - M50.93 M50.9 Cervical disc disorder, unspecified

S16.1 = Strain

S16.1.1XXA Strain of muscle, fascia and tendon at neck level, init
S16.1.1XXX Strain of muscle, fascia and tendon at neck level, sequel

724.4 - Lumbosacral IVD, w/Radiculopathy

Click to view/hide add'l coding info...

Notes:
- code to the most superior level of disorder
- includes cervicography and disc disorders with cervical radiculitic disc disorders

Code(s) Description
M50.00 - M50.03 M50.0 Cervical disc disorder with myelopathy
M50.10 - M50.13 M50.1 Cervical disc disorder with radiculopathy
M50.20 - M50.23 M50.2 Other cervical disc displacement
M50.30 - M50.33 M50.3 Other cervical disc degeneration
M50.80 - M50.83 M50.8 Other cervical disc disorders
M50.90 - M50.93 M50.9 Cervical disc disorder, unspecified
Key Takeaways

• Code to the highest degree of specificity
• Consult your tabular list until you are familiar with the codes
• Avoid redundancy
• ENGLISH vs. Numbers
• Smooth Sailing!

Essential Anatomy and Terminology

Let's Cover the Very Basics

• Skeletal System: 206 bones, cartilage and ligaments
• Axial Division: Trunk
• Appendicular Division: Appendages
• Condyle: Rounded end of bone
• Tendons: Anchor Muscle to Bone
• Ligaments: Anchor Bones to Bones

Core Chiro Terms

• -algia = pain
• -itis = inflammation
• -pathy = disease of, usually non-inflammatory
• -osis = state or condition of

Symptomology Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>723.1</td>
<td>Cervicalgia</td>
</tr>
<tr>
<td>723.2</td>
<td>Cervicalgia</td>
</tr>
</tbody>
</table>

Cervico = Neck  -Algia = Pain
Cervicalgia = Neck Pain

Coding Whiplash

• Sprain VS. Strain
  • S47.0: Sprain of Neck (Includes strain of joint capsule, ligament, muscle, tendon)

• S13.4 __ __ Sprain of ligaments of the cervical spine

• S16.1xxA STRAIN of muscle, fascia and tendon at neck level, initial encounter
Cervical Spine
- 7 vertebra: C1-C7
- Occiput
- Atlas = C1
- Axis = C2
- Atlanto-Axial = C1-C2
- Cervical Lordosis: refers to the curve of the spinal; could be hypo or hyper

Lordosis/Kyphosis
- Lordis – Bent to front
- Osis – state of
- Kypho – bent to back
- Hypo- not enough
- Hyper – too much

Thoracic Spine
- 12 Vertebra: T1-T12
- Also called the dorsal spine
- Kyphotic Curve
  - From the Greek: hump
  - AKA hunchback

Lumbar Spine
- 5 Lumbar Vertebra: L1-L5
- Pelvic
- Sacrum
- Coccyx
- Lumbar lordodic curve
- Many areas to understand below the belt

Intensity Guidelines
Intensity – Grading as follows:
* Minimal: When the symptoms or signs constitute an annoyance but cause no impairment in the performance of a particular activity.
* Slight: When the symptoms or signs can be tolerated but would cause some impairment in the performance of an activity that precipitates the symptoms or signs.
* Moderate: When the symptoms and signs would cause marked impairment in performance of an activity that precipitates the symptoms or signs.
* Marked: When the symptoms or signs preclude any activity that precipitates the symptoms or signs.

Very Common Prefix/Combining Forms for DX
- Brachio: Relating to the shoulder
- Cervico: Relating to the cervical spinal region
- Thoraco: Relating to the thoracic spinal region
- Lumbo: Relating to the lumbar spinal region
- Sacro: Relating to the sacral spinal region
- Radiculo: Relating to the nerve roots
- Costo: Relating to the ribs
- Neuro: Relating to the nerve
- Scolio: Being crooked or twisted
- Osteo: Relating to the bone
- Arthro: Relating to the joint, articulation
- Spondylo: Relating to the vertebra or vertebral column
- Cephalo: Relating to the head
- Myo: Relating to the muscle
**Anatomical Position-Facing Forward**

**Common Anatomical Terms**
- **Antalgic**: Any physical attitude assumed to gain relief of pain
- **Prone**: Lying face down
- **Supine**: Lying on the back, face up (also dorsal)

**Basic Anatomy-Directional Terms**
- **Anterior**: In front of, front
- **Posterior**: After, behind, following, toward the back
- **Distal**: Away from, farther from the origin
- **Proximal**: Near, closer to the origin
- **Dorsal**: Near the upper surface, toward the back
- **Ventral**: Toward the bottom, toward the belly
- **Superior**: Above, over
- **Inferior**: Below, under
- **Lateral**: Toward the side, away from the mid-line
- **Medial**: Toward the mid-line, middle, away from the side

**Terms of Motion**
- **Flexion**: The joint angle becomes smaller
  - A bent elbow is flexed
  - Cervical flexion is when the head is bowed forward
  - Bicep flexion is familiar
  - Lateral flexion is ear to shoulder

- **Hyper/hypo-flexion**: Too Much/Too Little Flexion

- **Extension**: The joint angle becomes larger
  - Cervical extension-head goes backward
  - Positive for pain when joint pinching occurs

- **Hyper/Hypo-Extension**: Too far, as in hyperextended knee

- **AB-duction**: Moving farther away from the mid-line

- **AD-duction**: Moving toward the midline
  - Usually in the shoulder, hip, fingers, toes
Musculoskeletal Prefixes

- **inter-** “between”
  - Intersegmental
  - Between the segments
- **Supra-** “above”
  - Supraspinatus
  - a muscle of the back of the shoulder that arises from the supraspinous fossa of the scapula

Combining Forms-Speed Round

- **Acetabul/o** – hip socket
- **Ankyl/o** – bent, fused
- **Arthr/o** – Joint
- **Burs/o** – fluid-filled sac in a joint
- **Carp/o** – carpals (wrist bones)

Combining Forms-Speed Round

- **Clavic/o, Clavicul/o** – clavicle (collar bone)
- **Cost/o** – Rib
- **Crani/o** – cranium (skull)
- **Femor/o** – thighbone
- **Humer/o** – humerus (upper arm bone)
- **Ili/o – illium** (upper pelvic bone)

Combining Forms-Speed Round

- **Kinesi/o** – movement
- **Kyph/o** – hump
- **Lamin/o** – lamina
- **Lord/o** – curve
- **Lumb/o** – lower back
- **Mandibul/o** – mandible (lower jawbone)

Combining Forms-Speed Round

- **Maxill/o** – maxilla (upper jawbone)
- **My/o, Musul/o** – muscle
- **Oste/o** – bone
- **Pelv/i** – pelvis (hip)
- **Phalang/o** – phalanges (finger or toe)
- **Pub/o** – pubis

Combining Forms-Speed Round

- **Rachi/o** – spine
- **Radi/o** – radius (lower arm)
- **Sacr/o** – sacrum
- **Scapul/o** – scapula (shoulder)
- **Scoli/o** – bent
- **Spondyl/o** – vertebra
- **Stern/o** – sternum (breast bone)
Combining Forms-Speed Round

- **Tars/o** – tarsal (ankle/foot)
- **Tend/o** – tendon (connective tissue)
- **Vertebr/o** – Vertebra

---

Head, Neck, Extra Spinal

- **98943 = Extraspinal Adjustments**
  - Includes upper extremities
  - Shoulder, elbow, wrist, hand, phalanges

---

97140/97124 Discussion

- **Cervical Diagnosis in ICD-10**

---

Cervical and Head Diagnoses

**SUBLUXATION**

- M99.30 Severe and traumatic dysfunction of head region
- M99.31 Severe and traumatic dysfunction of cervical region
- M99.32 Subluxation complex of vertex of head region
- M99.33 Subluxation complex of vertex of cervical region
- S13.100 Subluxation of unspecified cervical vertebra
- S13.101 Subluxation of C7/C1 cervical vertebra
- S13.200 Subluxation of C3/C4 cervical vertebra
- S13.210 Subluxation of C2/C3 cervical vertebra
- S13.300 Subluxation of C1/C2 cervical vertebra
- S13.310 Subluxation of unspecified cervical vertebra

---

Other Conditions

- Other cervical disc degeneration
- Other cervical disc protrusion
- Other cervical disc herniation
- Other cervical disc compression
- Other cervical disc herniation with radiculopathy
- Discitis
- Discitis with abscess
- Discitis with infection
- Discitis with accompanying radiculopathy
- Discitis with accompanying myelopathy
- Discitis with accompanying osteomyelitis
- Discitis with accompanying granulomatous discitis
- Discitis with accompanying granulomatous reaction
- Discitis with accompanying granulomatous abscess
- Discitis with accompanying granulomatous reaction and abscess
- Discitis with accompanying granulomatous abscess and osteomyelitis
- Discitis with accompanying granulomatous abscess and infection
- Discitis with accompanying granulomatous abscess and myelopathy
- Discitis with accompanying granulomatous abscess and radiculopathy
Cervicothoracic Junction

- Sit at a desk much?
- Text much?
- Look at your phone much?
- Patients have more and more challenges with forward head carriage

Upper Crossed Syndrome

- Responds well to active care
- Excellent DX when proving medical necessity for 97110
- Inhibited vs. tight
- Also lower crossed syndrome

Back Office CA’s Benefit from this Understanding!

Know Your Anatomy

- ICD-10 divides up the areas of focus
- Upper, mid, lower
- Occipital, Occipito-Cervical, Cervical, Cervico-Thoracic, and Thoracic

Terms of Motion

- **AB-duction**: Moving farther away from the mid-line
- **AD-duction**: Moving toward the midline
- Usually in the shoulder, hip, fingers, toes

An Example of 7th Digit

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S43.31</td>
<td>Subluxation and dislocation of scapula</td>
</tr>
<tr>
<td>S43.311</td>
<td>Subluxation of right scapula</td>
</tr>
<tr>
<td>S43.312</td>
<td>Subluxation of left scapula</td>
</tr>
<tr>
<td>S43.313</td>
<td>Subluxation of unspecified scapula</td>
</tr>
<tr>
<td>S43.314</td>
<td>Dislocation of right scapula</td>
</tr>
<tr>
<td>S43.315</td>
<td>Dislocation of left scapula</td>
</tr>
<tr>
<td>S43.316</td>
<td>Dislocation of unspecified scapula</td>
</tr>
</tbody>
</table>
Unspecified—Use Sparingly

- $43.00
  - Unspecified subluxation and dislocation of shoulder joint
  - Dislocation of humerus NOS
  - Subluxation of humerus NOS

- $43.001
  - Unspecified subluxation of right shoulder joint

- $43.002
  - Unspecified subluxation of left shoulder joint

- $43.003
  - Unspecified subluxation of unspecified shoulder joint

- $43.004
  - Unspecified dislocation of right shoulder joint

- $43.005
  - Unspecified dislocation of left shoulder joint

- $43.006
  - Unspecified dislocation of unspecified shoulder joint

Tissues of the Upper Extremity

- Cartilage
  - Protect and cover bones at the joints
  - Devoid of nerves and blood vessels
  - Takes a long time to heal

- Bursa
  - Fluid filled sac
  - Protects and lubricates joints

- Synovium
  - Fluid filled sac
  - Protects and lubricates tendons crossing joints

- Nerves
  - Send signals to and from brain and spinal cord

Upper Extremity Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>G81</td>
<td>Carpal tunnel syndrome</td>
</tr>
<tr>
<td>G82</td>
<td>Cubital tunnel syndrome</td>
</tr>
<tr>
<td>G83</td>
<td>Tarsal tunnel syndrome</td>
</tr>
<tr>
<td>G84</td>
<td>Medialentroneal syndrome</td>
</tr>
<tr>
<td>G85</td>
<td>Other peripheral nerve injuries</td>
</tr>
</tbody>
</table>

Upper Extremity Diagnosis Options

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>G81</td>
<td>Carpal tunnel syndrome</td>
</tr>
<tr>
<td>G82</td>
<td>Cubital tunnel syndrome</td>
</tr>
<tr>
<td>G83</td>
<td>Tarsal tunnel syndrome</td>
</tr>
<tr>
<td>G84</td>
<td>Medialentroneal syndrome</td>
</tr>
<tr>
<td>G85</td>
<td>Other peripheral nerve injuries</td>
</tr>
</tbody>
</table>

Upper Extremity Diagnosis Codes (Extra-Spinal)

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>D09</td>
<td>Anemia, other iron deficiency</td>
</tr>
<tr>
<td>E04</td>
<td>Hypothyroidism, mild</td>
</tr>
<tr>
<td>E05</td>
<td>Hypothyroidism, severe</td>
</tr>
<tr>
<td>G04</td>
<td>Carpal tunnel syndrome</td>
</tr>
<tr>
<td>G05</td>
<td>Cubital tunnel syndrome</td>
</tr>
<tr>
<td>G06</td>
<td>Tarsal tunnel syndrome</td>
</tr>
<tr>
<td>G07</td>
<td>Medialentroneal syndrome</td>
</tr>
<tr>
<td>G10</td>
<td>Other nerve injuries</td>
</tr>
</tbody>
</table>

Upper Extremity Diagnosis Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>G81</td>
<td>Carpal tunnel syndrome</td>
</tr>
<tr>
<td>G82</td>
<td>Cubital tunnel syndrome</td>
</tr>
<tr>
<td>G83</td>
<td>Tarsal tunnel syndrome</td>
</tr>
<tr>
<td>G84</td>
<td>Medialentroneal syndrome</td>
</tr>
<tr>
<td>G85</td>
<td>Other peripheral nerve injuries</td>
</tr>
</tbody>
</table>

Treatments of the Wrist and Hands

- Hand Bones
- Phalanges
- Meta-carpals
- Carpals
- Radius
- Ulna

(855) 832-6562
Upper Extremity Subluxation Codes

What Can You Do Now?
- Practice together
- Make flash cards
- Do internal quizzes
- Staff meeting games
- Practice auditing some files
- Review with the doctor
- Look at new cases and learn, learn, learn

Documentation Principles Drive ICD-10

The KMCU Way
- Documentation systems based on lots of audits and findings
- Basics are often the most missing items
- Training is the foundation
- Same as 1983—Not!!!
- What are we up against?

Ch-Ch-Ch-Ch-Changes
- Healthcare has been changing for a while
- The changes are getting more rapid and are hitting closer to home
- This event is about awareness
Chiropractic and the OIG

• For the first time since May 2010, the Office of Inspector General, of the Dept. of Health and Human Services, has published a report specifically about chiropractic...or rather, one chiropractor in particular.

OIG Report Facts

• This fellow chiropractor’s dire situation represents the current state of risk that most chiropractors are not even aware they face on a daily basis.
• Is this you?

Doctors AND Assistants in the Cross Hairs

Cookie Cutter Protocols Deemed Fraud

A Closer Look...

Haddad also referred clients to Dr. Kinsinger's Bridgport chiropractic offices, which operated under the name Health First Medical, P.C. Kinsinger often permitted Haddad to influence the course of patients' medical treatments by assuring to Haddad's instructions that a patient receive more treatment and diagnostic tests despite the questionable need for both.

Lynne and Jennifer Nettles are licensed chiropractors who worked for Kinsinger. Between approximately December 2006 and February 2008, Health First chiropractors performed unnecessary chiropractic treatments on Haddad's anti-accident clients. As part of the scheme, the chiropractors established a protocol to treat patients in Haddad's cases for six months, regardless of medical need, and would not order treatment of patients unless instructed to do so by Haddad. The chiropractors often falsified medical records by indicating that they had examined the patients when they had not, and by misrepresenting that patients' pain complaints and other symptoms continued. After the six-month period, each patient would receive a permanent partial disability rating, regardless of the permanence of the medical condition. If a patient had received a permanency rating for a prior accident, the protocol was to give a higher or different disability rating for the present accident. The chiropractic practice prepared false reports, which were then provided to the victim insurance carriers.

More than 10 insurance carriers lost at least $8.7 million as a result of this fraud scheme. The loss was directly attributable to Lynne’s dealings with Haddad clients in 812-245. Judge Underhill today ordered Lynne to pay restitution in that amount.
Not Just Medicare! This is PI

Waynesboro Chiropractor Sentenced to Prison for False Personal Injury Claim

U.S. Attorney’s Office
Middle District of Pennsylvania
June 19, 2014

The United States attorney’s office for the Middle District of Pennsylvania announced that a Waynesboro chiropractor was sentenced today to 18 months in prison for a pattern of submitting false claims to his insurance company.

Sentenced was Jorge J. Hernandez, 49, of Waynesboro, Pennsylvania, who was convicted in March 2013 of submitting false claims to his insurance company for services that were never rendered.

"Hernandez’s behavior demonstrates a pattern of deliberate deception for personal gain,“ said U.S. Attorney Brian W. rider. "Today’s sentence sends a clear message that insurance fraud will not be tolerated."

In March 2013, Hernandez admitted to submitting false claims for services that were never provided. He then submitted a payment for services that were never rendered and then submitted another claim for the same services.

Hernandez was sentenced to 18 months in prison today and ordered to serve three years of supervised release.

Medically Unnecessary Definitions

FOR IMMEDIATE RELEASE

Friday, March 6, 2015

New York Doctor Pleads Guilty in $54 Million Medicaid Fraud Scheme

A New York doctor pleaded guilty today for his involvement in a scheme to defraud Medicaid of $54 million in claims for medically unnecessary treatments.


Raman Joshi, 49, a former employee of New York Presbyterian, has pleaded guilty to one count of conspiracy to commit health care fraud.

"Thegid’s arrest today demonstrates the importance of transparency in the health care system," said U.S. Attorney Lynch. "By admitting to his role in this scheme, Joshi has taken responsibility for his actions and accepted the consequences of his conduct.

According to the plea agreement, Joshi admitted to his role in the scheme to defraud Medicaid.

And so it goes....
OIG FY 2012 Report to Congress

In November 2011, a Federal grand jury returned an indictment charging six defendants, including three medical doctors and a chiropractor, for their alleged participation in a fraud scheme at two medical clinics in Houston. The indictment states that defendants provided a variety of spa services such as massages and facials, while billing Medicare for physical therapy and other services that were medically unnecessary and never provided. The defendants also recruited Medicare beneficiaries to their clinic by offering lunches and dancing classes, in exchange for the beneficiaries providing their Medicare numbers to be billed for medical services that they did not need and never received.

And Literally Last Month...

Job Openings

Experienced Litigation Attorney

- ACPD seeks experienced litigation to represent OIGs in the litigation and settlement of administrative litigation matters involving OIG’s administrative sanctions (i.e., civil monetary penalties and exclusions) for false claims, kickbacks, sub-standard quality of care, and other conduct. During the last fiscal year, OIG recovered more than $37 million through 123 administrative cases. OIG is building a team of attorneys to focus on OIG-initiated administrative enforcement, and is seeking experienced litigators to fill the team. The candidates may also represent OIGs in civil litigation and settlement, appeals of program exclusions, monitoring of Corporate Integrity Agreements, and resolution of self-disclosed conduct. Application deadline is August 12, 2015.

Announcement: Experienced Litigation Attorney

Audit: Efficiency Check; A systematic check or assessment, especially of the efficiency or effectiveness of an organization or process, typically carried out by an independent assessor
What Does This Mean?

- Records requests come in all shapes and sizes
- Sometimes they are a "probe"
- Sometimes they are a "system"
- Sometimes they are what they are

Who's Asking??

- Commercial insurance Carrier
- Personal Injury Carrier or Adjuster
- Worker's Compensation Carrier or Adjuster
- Medicare Administrative Contractor (MAC)
- Recovery Audit Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Zone Program Integrity Contractor (ZPIC)
- Program Safeguard Contractor (PSC)

Why Are They Asking??

- Prepayment review of claims always results in an "initial determination"
- Post-payment review may result in no change to the initial payment to the provider or may result in a "revised determination" that would require the provider to pay back monies for services determined to be "not reasonable or necessary.”
- Automatic, or non-complex, reviews occur without clinical review of medical documentation submitted by the provider, such as in cases of medically unlikely edits (MUEs) or when there is no timely response to an audit request letter.
- Complex reviews involve requesting, receiving, and medical review of additional documentation associated with a claim.

What's Their Motivation?

- Payment Recovery/Recoupment: An overpayment occurs when a provider receives excess payment due to
  - duplicate submission of the same service or claim,
  - payment to the incorrect payee,
  - payment for excluded or medically unnecessary services, or
  - a pattern of furnishing and billing for excessive of non-covered services, as determined in an audit or review.

- In 2010, President Obama announced the following three goals for cutting improper Medicare payments by 2012:
  - reducing overall payment errors by $50 billion
  - cutting the Medicare fee-for-service error rate in half
  - recovering $2 billion in improper payments
They Look For…

- Coding Errors and Patterns
- Review Outliers
- Review of high dollar codes-BCBSIL SO’s
- Identify Fraud and Abuse
- This is JOB ONE!

What Might Be the Trigger?

- Overutilization
- New carrier—pre-existing condition
- Unusual codes
- Unusual errors
- Billing errors, like lack of Box 14 changing
- Your number came up

Why Is Documentation So Important?

- Ensures quality patient care
- Meets licensure requirements to protect the public
- Guards against malpractice action
- Secures appropriate reimbursement
- Because...if it wasn’t written down, it didn’t happen!

Know your Audience

- Another health care provider
- Your board
- A malpractice attorney
- Third party payer's medical necessity auditor
- Each has different, but necessary requirements of your documentation

What Dr. Diep Didn’t Know That He Didn’t Know!

- The $708,000 recoupment finding to Medicare:
  - Ignorance of the rules
  - Upcoding charges
  - Billing Medicare inappropriately
  - Poor documentation
  - No Policies and SOP
  - Ignored help when notified of OIG concerns

OIG Report Facts

- The OIG is not “out to get us all”
- There is enough “low hanging fruit” to take care of the federal budget deficit
- Be aware of the specific errors pointed out in the report
Problem #1: Stick Out Like a Sore Thumb!

Size Matters

- This doctor was in the top 5 in the entire country for volume of CMT codes billed. Top 5!!!
- He billed an outrageous percentage of 98942, all 5 spinal regions!

So? I’m a Full Spine Adjuster!

- Medical necessity definition dictates that you must prioritize each area of complaint
- Every visit:
  - S + O (P + ART) for every region treated
  - 2 DX codes for each region
  - Treatment plan for each/short and long term goals

Why It LOOKS Fishy...

And Just This Week...

The Guideline and Expectation

"The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patients condition and provide reasonable expectation of recovery or improvement of function."
### Problem #2: Did Not Understand The Definitions of Maintenance Care

- He ONLY billed AT modifier, never ever moving a patient to maintenance care.
- Even in the details of the rebuttal from his attorney, he also argued that he "never delivered care that was not AT Modifier worthy".

### Understand the Rules

- Clinically Appropriate Care
  - Life enhancing
  - Symptom relieving
  - Wellness care
  - Supportive care
  - Maintenance care

- Medically Necessary Care
  - Yields a significant improvement in clinical findings and patient functionality.

### Is All Care Medically Necessary?

GA Modifier

**CMS defines Maintenance Therapy as:**

"Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."
What's Wrong with this Picture?

B. Patient Name: ________________

C. Identification Number: ________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _________ below.

<table>
<thead>
<tr>
<th>Service</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>not a covered service</td>
<td>$16-5150 range</td>
</tr>
<tr>
<td>X-Rays</td>
<td>not a covered service</td>
<td>$40-1100 range</td>
</tr>
<tr>
<td>Therapy</td>
<td>not a covered service</td>
<td>$10-220 range</td>
</tr>
<tr>
<td>Maintenance Treatment</td>
<td>not a covered service</td>
<td>$35-575 range</td>
</tr>
<tr>
<td>Spinal Decompression</td>
<td>not a covered service</td>
<td>$50</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>not a covered service</td>
<td>$10-95 range</td>
</tr>
<tr>
<td>Supports, Biofeeds, Ice Pads, Tihes, etc.</td>
<td>not a covered service</td>
<td>$10-50 range</td>
</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:

Aha!

Voluntary Use = “MAY I?”

WHEN MAY I ISSUE AN ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the “What Claims Reporting Modifiers Do I Use?” section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.

ABN for Voluntary Use

You should only provide ABNs to beneficiaries of National-Origin (Fee-For-Service) Medicare. The ABN allows the beneficiary to consent to whether to get services and accept financial responsibility for the services. If Medicare does not pay, the ABN serves as proof that the beneficiary knew prior to receiving care that Medicare might not pay. If you do not issue a voluntary ABN, Medicare will not bill the beneficiary for the service and you may not be able to submit a claim for payment.

The ABN also serves as an optional (voluntary) benefit to forewarn beneficiaries of their financial liability prior to providing care Medicare does not cover. Medicare does not require you to issue an ABN in order to bill a beneficiary for an item or service that is not a Medicare benefit and never covered.

- When you issue the ABN as a voluntary benefit, the beneficiary does not check an option box or sign and date the notice.

A Better Way

Our Medicare Fees

Definition of Case Management

Case management

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
Episodes of Care

• The foundation for an episode is contained in the beginning four steps of documentation.
• There was confusion about what an episode of care is.
• Therefore, the documentation necessary was NOT present.

Blatant Disregard

• Medicare documentation requirements are published.
• We, as doctors, must know how to diagnose, treat in episodes of care and dismiss patients from active treatment.
• Have written policies and procedures.

Any Patients in Your Office in this Circumstance?

For example, Deep Chiropractic received payment for a chiropractic service provided on December 29, 2010, to a 74-year-old Medicare beneficiary. The medical review contractor determined that the medical records did not support the medical necessity of the service because manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and predictable length of time. This beneficiary received 17 chiropractic services during CYs 2010 and 2011.

Problem #4: Didn’t Understand Requirements and How to Use Software to Meet Them

What the OIG Did in This Case

Exact OIG Recommendations

• Refund $708,022 to the Federal Government and
• Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.
Extrapolation at Its Finest

WHAT WE FOUND

Of the 100 sampled chiropractic services, 7 services were allowable in accordance with Medicare requirements. The remaining 93 services were not allowable. 70 were medically unnecessary, 11 were incorrectly coded, 8 were undocumented, and 3 were insufficiently documented. As a result, Deep Chiropractic returned $3,106 in allowable Medicare payments.

On the basis of our sample results, we estimated that at least $708,022 of the $879,858 paid to Deep Chiropractic for chiropractic services, or approximately 80 percent of the total amount paid, was not allowable for Medicare reimbursement. These payments occurred because Deep Chiropractic did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary, correctly coded, and adequately documented.

Sure, let me just get my checkbook!

WHAT WE RECOMMEND

We recommend that Deep Chiropractic:

• Refund $708,022 to the Federal Government.
• Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.

They Talked to Patients

HOW WE CONDUCTED THIS REVIEW

For CYs 2010 and 2011, Deep Chiropractic received Medicare Part B payments of $879,858 for 25,714 chiropractic services provided to Medicare beneficiaries by the selected chiropractor. We reviewed a random sample of 100 chiropractic services (1% of the total payments to Deep Chiropractic). We randomly selected services for review to determine whether they were allowable.

Don’t Learn the Hard Way!

• The simple steps that could have been taken to avoid this nightmare.
• How expensive was his inaction?
• $708K back to the government, and probably losing Medicare privileges!
• Don’t let this be YOU!

What Should You Do Now?

A Warning the Should be Heeded

WHAT WE FOUND

Of the 100 sampled chiropractic services, 7 services were allowable in accordance with Medicare requirements. The remaining 93 services were not allowable. 70 were medically unnecessary, 11 were incorrectly coded, 8 were undocumented, and 3 were insufficiently documented. As a result, Deep Chiropractic returned $3,106 in allowable Medicare payments.

On the basis of our sample results, we estimated that at least $708,022 of the $879,858 paid to Deep Chiropractic for chiropractic services, or approximately 80 percent of the total amount paid, was not allowable for Medicare reimbursement. These payments occurred because Deep Chiropractic did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary, correctly coded, and adequately documented.
The purpose of a compliance program is:
To integrate policies and procedures into the physician’s practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services.

Is it Mandatory?
• Came out of the sentencing guidelines
• Affordable Care Act: Mandatory Compliance Plans Coming Soon
• CMS has NOT finalized the requirements
• CMS will advance specific proposals at some point in the future

Just Do it! Compliance Program!
• The truth is, we’ve been being told that since 2001.
• Get your policies and procedures and OIG compliance plan in place.
• It’s too easy to do, and if you don’t know how, ask us! We teach this every weekend!! Don’t delay.

Medical Review Policies
Aetna
BCBS

[Images of Aetna and BCBS medical review policies]

[Image of spine diagram with spinal sites and levels]
Assessment = Dr. Thinking

Assessment = Diagnosis

WHAT THE !@#$?

Assessment = Case Management

- Treatment and/or manipulative services rendered by a practitioner must be due to a significant health problem in the form of a neuromusculoskeletal condition and have a direct therapeutic relationship to the patient’s condition.

- The patient’s medical record including ALL of the following necessary components:
  - Date/Time of Visit
  - Patient Identification
  - Initial patient information
  - Patient demographics, sex and occupation
  - Health history with dates, comorbid conditions, description
  - Review of systems, treatment rendered
  - Exam/Diagnostic findings (must specify diagnostic tests/imaging performed)
  - Clinical impressions
  - Progress notes
  - Clinical information
  - Adjustment/Manipulation information
  - All services require initials (written or electronic) identifying anyone rendering services other than attending DC/DO
  - Re-examination/Re-assessment
  - Records must be clear and legible
  - Attending DC/DO should at minimum sign all evaluations/re-evaluations
  - Reasonable expectation of significant improvement in the patient’s condition / Addition of a reasonable period of time

FINANCIAL RESPONSIBILITY OF CHIROPRACTIC CARE

Patient Relationship Over Time

Course of Treatment

Insurance Co. May Be Financially Responsible

Incident

1-2 Visits

May or May Not Include Separate Identifiable E/M Code
Episodes of Care

Medicare Documentation Guidelines

Job 1--Dr. Listening

Job 2--Dr. Finding
Job 3--Dr. Thinking

- This is initial assessment (S+O)
- H + E = D => Tx Plan
- Diagnosis for each region you plan to treat
- Treatment plan is obvious based on DX
- DX and plan for each component service

Job 4--Dr. Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear, if necessary
- It’s logical to expect to see the treatment coded that you chose

When Using Exam Findings

- You must be able to defend your diagnosis
- Kemp’s test is positive in most facet syndromes, but in some facet syndromes are not
- Be able to tell a third party what your thought process was using what’s written in your patient record

EHR DX and Assessment Samples

DIAGNOSIS:
I am considering the information available. I have diagnosed Lily Astan with (830.03) Cervical Subluxation, (725.2) Brachial neuritis, (728.6) Cervical myofascitis

ASSESSMENT:
After a consultation of the information available, I have diagnosed Lily Astan with (830.03) Cervical Subluxation, (725.2) Brachial neuritis, (728.6) Cervical myofascitis. Based on her history of no complicating factors and nothing as contraindications, it is reasonable to believe that her recovery may take about the same time as an average patient with an uncomplicated case.
Mechanism of Injury (MOI)
• The manner in which a physical injury occurred, such as a fall from a height, ground-level fall, high or low speed MVA, etc.

Medicare Specifics
• Claims can be denied without documented mechanisms of injury
• Per Medicare: patient can’t just come in with a headache and expect Medicare to pay for the care of that headache
• Some Medicare contractors are even going so far as to say that the injury can’t be incurred during activities of daily living
• For example, patient wakes up in the morning with bad neck pain; denial says that the claim is denied because sleeping is an activity of daily living

Documentation in History
• Best to record a mechanism of trauma for every new patient or new episode.
• Ask leading questions of your patient to elicit a specific incident that precipitated the pain that the patient is experiencing.
  • “Prior to experiencing your low back pain, did you slip or fall? Were you doing any unusual activity? When did you first experience the pain? Can you recall anything unusual that happened prior to experiencing the pain?”
• Record any incident that the patient can relate that ties to the pain that brought them into your office

Medicare Specifics
• Claims can be denied without documented mechanisms of injury
• Per Medicare: patient can’t just come in with a headache and expect Medicare to pay for the care of that headache
• Some Medicare contractors are even going so far as to say that the injury can’t be incurred during activities of daily living
• For example, patient wakes up in the morning with bad neck pain; denial says that the claim is denied because sleeping is an activity of daily living

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

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

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 (criminal 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).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.
V – Y Codes
Chapter 20: Guidelines for external causes of morbidity (V00-Y99)

• Never sequenced first
• Provide data about the cause, intent, place, activity, or status of the accident or patient
• No national requirement to use these codes, but voluntary reporting is encouraged

Y92 Place of occurrence should be listed after other codes, used only once an initial encounter, in conjunction with Y93

Y93 Activity code should be used only once, at initial encounter

Do You Use E Codes Now?

• E codes are intended to identify how a poisoning or injury occurred, the cause; whether the injury was accidental or intentional, the intent; and the place where the accident or event took place, i.e., place of occurrence. E codes identifying the “place of occurrence,” E849.X, are to be used in conjunction with E codes from ranges E850-E869 and E880-E928

E Codes in ICD-9 Expanded

• External Cause Codes
• Do you use them?

E844.8
• Sucked up into a jet without damage to the airplane; ground crew

ICD-10-CM Increased Specificity

Updated Code V97.33
Sucked into a jet without damage to the airplane

Say What??

• W22.01xD
  Walked into wall, subsequent encounter

• Y34
  Unspecified event, undetermined intent

• R45.2
  Unhappiness

ICD-10-CM Diagnosis Codes

20. External causes of morbidity (V00-Y99) Minor Guidelines

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V00-V08</td>
<td>Accidents (V00-V08)</td>
</tr>
<tr>
<td>X71-183</td>
<td>Unspecified event (X71-183)</td>
</tr>
<tr>
<td>Y90-Y99</td>
<td>Supplementary factors related to causes of morbidity, classified elsewhere (Y90-Y99)</td>
</tr>
</tbody>
</table>
Intention Clarified

Y21-Y33 Event of undetermined intent (Y21-Y33) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y21.X0.XA - Y21.X3.XX</td>
<td>Y21 Drowning and submersion, undetermined intent</td>
</tr>
<tr>
<td>Y22.X0.XA - Y22.X3.XX</td>
<td>Y22 Handgun discharge, undetermined intent</td>
</tr>
<tr>
<td>Y23.X0.XA - Y23.X3.XX</td>
<td>Y23 Rifle, shotgun and large firearm discharge, undetermined intent</td>
</tr>
<tr>
<td>Y24.X0.XA - Y24.X3.XX</td>
<td>Y24 Other and unspecified firearms and firearm discharge, undetermined intent</td>
</tr>
<tr>
<td>Y25.X0.XA - Y25.X3.XX</td>
<td>Y25 Contact with explosive material, undetermined intent</td>
</tr>
<tr>
<td>Y26.X0.XA - Y26.X3.XX</td>
<td>Y26 Exposure to smoke, fire and flames, undetermined intent</td>
</tr>
<tr>
<td>Y27.X0.XA - Y27.X3.XX</td>
<td>Y27 Contact with steam, hot vapors and hot objects, undetermined intent</td>
</tr>
<tr>
<td>Y28.X0.XA - Y28.X3.XX</td>
<td>Y28 Contact with sharp object, undetermined intent</td>
</tr>
<tr>
<td>Y29.X0.XA - Y29.X3.XX</td>
<td>Y29 Contact with blunt object, undetermined intent</td>
</tr>
<tr>
<td>Y30.X0.XA - Y30.X3.XX</td>
<td>Y30 Falling, jumping or pushed from a high place, undetermined intent</td>
</tr>
<tr>
<td>Y31.X0.XA - Y31.X3.XX</td>
<td>Y31 Falling, lying or running before or into moving object, undetermined intent</td>
</tr>
<tr>
<td>Y32.X0.XA - Y32.X3.XX</td>
<td>Y32 Crashing of motor vehicle, undetermined intent</td>
</tr>
<tr>
<td>Y33.X0.XA - Y33.X3.XX</td>
<td>Y33 Other specified events, undetermined intent</td>
</tr>
</tbody>
</table>

X92-Y08 Assault (X92-Y08) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X92.X0.XA - X92.X3.XX</td>
<td>X92 Assault by drowning and submersion</td>
</tr>
<tr>
<td>X93.X0.XA - X93.X3.XX</td>
<td>X93 Assault by handgun discharge</td>
</tr>
<tr>
<td>X94.X0.XA - X94.X3.XX</td>
<td>X94 Assault by rifle, shotgun and large firearm discharge</td>
</tr>
<tr>
<td>X95.X0.XA - X95.X3.XX</td>
<td>X95 Assault by other and unspecified firearms and firearm discharge</td>
</tr>
<tr>
<td>X96.X0.XA - X96.X3.XX</td>
<td>X96 Assault by explosive material</td>
</tr>
<tr>
<td>X97.X0.XA - X97.X3.XX</td>
<td>X97 Assault by smoke, fire and flames</td>
</tr>
<tr>
<td>X98.X0.XA - X98.X3.XX</td>
<td>X98 Assault by steam, hot vapors and hot objects</td>
</tr>
<tr>
<td>X99.X0.XA - X99.X3.XX</td>
<td>X99 Assault by sharp object</td>
</tr>
<tr>
<td>Y00.X0.XA - Y00.X0.XX</td>
<td>Y00 Assault by blunt object</td>
</tr>
<tr>
<td>Y01.X0.XA - Y01.X3.XX</td>
<td>Y01 Assault by pushing from high place</td>
</tr>
<tr>
<td>Y02.X0.XA - Y02.X3.XX</td>
<td>Y02 Assault by pushing or placing victim in front of moving object</td>
</tr>
<tr>
<td>Y03.X0.XA - Y03.X3.XX</td>
<td>Y03 Assault by crushing of motor vehicle</td>
</tr>
<tr>
<td>Y04.X0.XA - Y04.X3.XX</td>
<td>Y04 Assault by bodily force</td>
</tr>
<tr>
<td>Y07.X1.XA - Y07.X7.XX</td>
<td>Y07 Depurator of assault, maltreatment and neglect</td>
</tr>
<tr>
<td>Y08.X0.XA - Y08.X0.XX</td>
<td>Y08 Assault by other unspecified means</td>
</tr>
<tr>
<td>Y09</td>
<td>Assault by unspecified means</td>
</tr>
</tbody>
</table>

V00-X58 Accidents (V00-X58) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V00.X0.XA - V00.X3.XX</td>
<td>V00-V09 Pediatric injured by transport accident (V00-V09)</td>
</tr>
<tr>
<td>V01.X0.XA - V01.X3.XX</td>
<td>V01-V19 Child seated in car injured in transport accident (V01-V19)</td>
</tr>
<tr>
<td>V02.X0.XA - V02.X3.XX</td>
<td>V02-V29 Motorcycle rider injured in transport accident (V02-V29)</td>
</tr>
<tr>
<td>V03.X0.XA - V03.X3.XX</td>
<td>V03-V39 Operator of three-wheeled motor vehicle injured in transport accident (V03-V39)</td>
</tr>
<tr>
<td>V04.X0.XA - V04.X0.XX</td>
<td>V04-V89 Car occupant injured in transport accident (V04-V89)</td>
</tr>
<tr>
<td>V05.X0.XA - V05.X9.XX</td>
<td>V05-V99 Occupant of pickup truck or van injured in transport accident (V05-V99)</td>
</tr>
<tr>
<td>V06.X0.XA - V06.X9.XX</td>
<td>V06-V99 Operator of heavy transport vehicle injured in transport accident (V06-V99)</td>
</tr>
<tr>
<td>V07.X0.XA - V07.X9.XX</td>
<td>V07-V99 Box-car occupant injured in transport accident (V07-V99)</td>
</tr>
<tr>
<td>V08.X0.XA - V08.X9.XX</td>
<td>V08-V99 Other land transport accidents (V08-V99)</td>
</tr>
<tr>
<td>V09.X0.XA - V09.X9.XX</td>
<td>V09-V99 Water transport accidents (V09-V99)</td>
</tr>
<tr>
<td>V10.X0.XA - V10.X9.XX</td>
<td>V10-V99 Air and space transport accidents (V10-V99)</td>
</tr>
<tr>
<td>V11.X0.XA - V11.X9.XX</td>
<td>V11-V99 Other unspecified transport accidents (V11-V99)</td>
</tr>
</tbody>
</table>

X92-Y08 Assault (X92-Y08) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y92.X0.XA - Y92.X3.XX</td>
<td>Y92 Assault by drowning and submersion</td>
</tr>
<tr>
<td>Y93.X0.XA - Y93.X3.XX</td>
<td>Y93 Assault by handgun discharge</td>
</tr>
<tr>
<td>Y94.X0.XA - Y94.X3.XX</td>
<td>Y94 Assault by rifle, shotgun and large firearm discharge</td>
</tr>
<tr>
<td>Y95.X0.XA - Y95.X3.XX</td>
<td>Y95 Assault by other and unspecified firearms and firearm discharge</td>
</tr>
<tr>
<td>Y96.X0.XA - Y96.X3.XX</td>
<td>Y96 Assault by explosive material</td>
</tr>
<tr>
<td>Y97.X0.XA - Y97.X3.XX</td>
<td>Y97 Assault by smoke, fire and flames</td>
</tr>
<tr>
<td>Y98.X0.XA - Y98.X3.XX</td>
<td>Y98 Assault by steam, hot vapors and hot objects</td>
</tr>
<tr>
<td>Y99.X0.XA - Y99.X3.XX</td>
<td>Y99 Assault by sharp object</td>
</tr>
<tr>
<td>Y00.X0.XA - Y00.X0.XX</td>
<td>Y00 Assault by blunt object</td>
</tr>
<tr>
<td>Y01.X0.XA - Y01.X3.XX</td>
<td>Y01 Assault by pushing from high place</td>
</tr>
<tr>
<td>Y02.X0.XA - Y02.X3.XX</td>
<td>Y02 Assault by pushing or placing victim in front of moving object</td>
</tr>
<tr>
<td>Y03.X0.XA - Y03.X3.XX</td>
<td>Y03 Assault by crushing of motor vehicle</td>
</tr>
<tr>
<td>Y04.X0.XA - Y04.X3.XX</td>
<td>Y04 Assault by bodily force</td>
</tr>
<tr>
<td>Y07.X1.XA - Y07.X7.XX</td>
<td>Y07 Depurator of assault, maltreatment and neglect</td>
</tr>
<tr>
<td>Y08.X0.XA - Y08.X0.XX</td>
<td>Y08 Assault by other unspecified means</td>
</tr>
<tr>
<td>Y09</td>
<td>Assault by unspecified means</td>
</tr>
</tbody>
</table>

X24-Y38 Legal intervention, operations of war, military operations, and terrorism (X24-Y38) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y24.X0.XA - Y24.X3.XX</td>
<td>Y24 Legal intervention, operations of war, military operations, and terrorism</td>
</tr>
<tr>
<td>Y25.X0.XA - Y25.X3.XX</td>
<td>Y25 Misdemeanors associated with adverse incidents in diagnostic and therapeutic care (Y25-X3)</td>
</tr>
<tr>
<td>Y26.X0.XA - Y26.X3.XX</td>
<td>Y26 Medical procedures associated with adverse incidents in diagnostic and therapeutic care (Y26-X3)</td>
</tr>
</tbody>
</table>

Y62-Y84 Complications of medical and surgical care (Y62-Y84) [Show Guidelines]

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y62.X0.XA - Y62.X0.XX</td>
<td>Y62-Misdemeanors associated with adverse incidents in diagnostic and therapeutic care (Y62-X0)</td>
</tr>
<tr>
<td>Y63.X0.XA - Y63.X0.XX</td>
<td>Y63-Misdemeanors associated with adverse incidents in diagnostic and therapeutic care (Y63-X0)</td>
</tr>
</tbody>
</table>

(855) 832-6562
Y-92 Series: Place of Occurrence

Y92 Place of occurrence of the external cause

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y92.00</td>
<td>Y92.0 Non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.10</td>
<td>Y92.1 Institutional (non-residence) as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.20</td>
<td>Y92.2 School, other institution and public administrative area as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.30</td>
<td>Y92.3 Sports and athletics area as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.40</td>
<td>Y92.4 Street, highway and other paved roadways as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.50</td>
<td>Y92.5 Trade and service area as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.61</td>
<td>Y92.6 Industrial and construction area as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.70</td>
<td>Y92.7 Farms as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.80</td>
<td>Y92.8 Other places as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>Y92.90</td>
<td>Unexpected place or not applicable</td>
</tr>
</tbody>
</table>

Look Up Several Common Codes


V, W, X, Y Codes For Fun

- Bus Occupant V79.9 (collision with) Animal in traffic being ridden
- Bus Occupant V70.3 (collision with) animal, non-traffic
- Bus Occupant V70.4 (collision with) animal, while boarding or alighting

What is the Tabular List?

Tabular list is the ONLY index where ALL code information is found.

Contains specific and complete code detail necessary to code correctly.

Final codes to be selected will be identified in this list.

ChiroCode Complete and Easy ICD-10 Coding for Chiropractic

Pages 1-43: Complete guide to understanding ICD-10-CM coding
Pages 44-56: Commonly Used Codes*
Pages 57-134: Code Map (GEMs)*
Pages 135-454: Tabular list (abridged)
Pages 455-472: Alphabetic Index*
Pages 473-511: Coding Guidelines

(855) 832-6562
Tabular list layout

Chapter 21 of them from A to Z (body system or condition)

Block

Ranges of categories (related conditions)

Categories

3 characters (more specific condition)

Subcategories

4th or 5th characters (etiology, location, etc.)

Codes

6th or 7th characters (laterality, encounter, etc.)

Tabular List

Chapter: 13, Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)
(always white font in a black box)

Other blocks of interest within Chapter 13

- M00 to M25, Arthropathies (diseases of the joints)
- M40 to M43, Dorsopathies (diseases of the spine)
- M45 to M49, Spondylopathies (diseases of the vertebrae)
- M50 to M54, Other Dorsopathies
- M60 to M63, Disorders of Muscles
- M65 to M67, Disorders of synovium and tendons
- M70 to M79, Other soft tissue disorders
- M80 to M84, Osteopathies and Chondropathies (diseases of bone and cartilage)
- M99 Biomechanical Lesions, NEC (subluxations and others)

Note: There are actually 19 blocks in Chapter 13. Each block deals with a specific disease and associated symptoms.
### Spondylopathies (M45-M49)

- **M45** Ankylosing Spondylitis
- **M46** Other Inflammatory Spondylopathies
- **M47** Spondylosis
- **M48** Other Spondylopathies
- **M49** Spondylopathies in diseases classified elsewhere

### Subcategories

#### M47 Spondylosis

- **M47.0** Anterior spinal artery compression syndromes
- **M47.1** Other Spondylosis with myelopathy
- **M47.2** Other Spondylosis with radiculopathy
- **M47.8** Other Spondylosis

---

**Note:** Codes may be complete with fewer than 6 characters. Some codes only have 3.

- **M47.812** Spondylosis without myelopathy or radiculopathy, cervical region

### ICD-10 examples

- **M25.652** Stiffness of left hip, not elsewhere classified
ICD-10 examples

M25.65 Stiffness of hip, not elsewhere classified

Note: this is the subcategory

ICD-10 examples

M25.6 Stiffness of joint, not elsewhere classified

Note: the exclusion notes apply to all codes that begin with M25.6

ICD-10 examples

M25 Other joint disorder, not elsewhere classified

Note: the exclusion notes apply to all codes that are in the M25 category

ICD-10 examples

M25 Other joint disorders (M20-M25)

Note: the exclusion notes apply to all codes in the M20-M25 block

ICD-10 examples

M25.652 Stiffness of left hip, not elsewhere classified

Note: in column instructions all the way back to the first character apply to this code. There were no exclusions at the code, but we found them in three other places as we worked backwards.

Coding tip: start with the specific code and work backwards to find the relevant instructional notes.
Tabular List Tips

• Read the complete definition of a code before determining if it is appropriate
• Reference instructions in each Block, Category and Subcategory
• Do NOT code directly from the Alphabetic Index or GEMS
  • These indexes are intended as a beginning reference point to direct you to the appropriate code
  • Final code determination should be confirmed in the Tabular List
• Never guess or assume

Quick but Quality Routine Visit Documentation

Two Most Common Documentation Errors

• Not understanding the difference between active and maintenance treatment
• The erroneous assumption that the PART process was all that was needed to document medical necessity

Error Rate Information

• Insufficient documentation is a known issue in the chiropractic profession
• Failure to provide any documentation to auditors represents nearly 50% of the poor scores
Three Covered Visit Types

- Requirements are straightforward
- Can be easily followed
- PART is a part – a subset – of each type of visit
- Learn the medical necessity rules and know your carrier’s LCD

Subsequent Visits Documentation Requirements

- **History**: (29% Documentation Error Rate)
  - Review of Chief Complaint
  - Changes since last visit
  - System review if relevant

- **Physical exam**: (43% Documentation Error Rate)
  - Exam of area of spine involved in diagnosis – Objective (A, R, T)
  - Assessment of change in patient condition since last visit (PE, OA, ADL, QVAS) (Same, Better, Worse)
  - Evaluation of treatment effectiveness (Same, Better, Worse, How and Why)

- **Daily Treatment Documentation**: (15% Documentation Error Rate)

Medical Necessity

It is our policy to clearly document for medical necessity, and bill a third party payer only for medically necessary care rendered. It is our policy to stay current with all medical review policies and comply with any contractual obligations to third party payers.

Therefore we maintain and keep current the medical necessity definitions and medical review policies of the carriers with which we participate in a contractual agreement.

These policies for medical necessity are reviewed at least once a year.
Preventative or maintenance care defined as care to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function.

Episodes of Care

- Wellness
- Prevent disease
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

GA Modifier

With Clinically Appropriate Care, less is more!
The Process

• Start by identifying your ICD-9 Codes and mapping them to ICD-10 Codes
• Confirm with the tabular list
• Code to the highest degree of specificity
• Remember to review the notes, not just ICD-9s

Let’s Get Started

Case #1
54 y.o male presented at the office for an initial visit complaining of right posterior mid-neck pain with pain also present in the right upper and mobile fingertip muscle. The neck pain is constant, as he end can be sharp with certain movements, the right arm pain is burning and achy constantly. He also stated that it felt like his muscles are cramping. The event was after a workout at the gym last week lifting weights. He stated he heard a pop and it felt like something ripped in his neck and he reported a pulse rate of 87/70, noting the pain is worse at the end of the day especially when performing computer work. The pain is temporarily reduced with ice and OTC medications. His job requires 20-30 hours of computer work per week. Cervical plain films reveal narrowing of C4-C5 and C5-C6 disc spaces, including a break in George’s Line at those levels.

ICD-9 Code:
933.3 Cervical Root Lesions
722.4 Degeneration of a Cervical Intervertebral Disc
844.12 Sprain/Strain of the Neck
728.95 Spasm of Muscle

Case 1 Answers and Rationale

• M50.12 Cervical Disc Disorder with radiculopathy, mid cervical region
• G54.2 Cervical Root disorder, NEC not used because of

How Did You Do?

Map the Root Lesion Code

The following ICD-9 Codes are generally equivalent to this code: E59.32:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G54.2</td>
<td>Cervical root disorders, not elsewhere classified</td>
</tr>
</tbody>
</table>

Excludes 1 Note

G54.2 Excludes 1: current traumatic nerve root and cervical disorder - see nerve root lesion by body region - intervertebral disc disorders (M51-M54)

The More Significant Code

M50.12 - Cervical Disc disorder with radiculopathy
G43.1 Disc disorder with radiculopathy
G43.1 Disc disorder with radiculopathy
G53.2 Cervical root disorder due to disc disorder
G53.2 Cervical root disorder due to disc disorder

M50.12 Excludes 1: current traumatic nerve root and cervical disorder - see nerve root lesion by body region - intervertebral disc disorders (M51-M54)

M50 Notes:
code is the most superior level of disorder
Includes: cervicomedullary disorders with radiculopathy

M54.1 Excludes 1: current traumatic nerve root and cervical disorder - see nerve root lesion by body region - intervertebral disc disorders (M51-M54)

M54 Notes:
Use the anatomical cause following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition.

M59.1 Excludes 1: current traumatic nerve root and cervical disorder - see nerve root lesion by body region - intervertebral disc disorders (M51-M54)

M59 Notes:
Use an anatomical cause following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition.
What's the Difference?

- **Excludes 1**
  A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes 1 note indicates that the code excluded is not part of the condition represented by the code, but a patient may have both the excluded and the same code together. Such conditions are considered part of the same diagnosis.

- **Excludes 2**
  A type 2 Excludes note represents "Not included here." An Excludes 2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both the code and the excluded code together, when appropriate.

Case 1 Answers and Rationale

- **M50.12** Cervical Disc Disorder with radiculopathy, mid cervical region
  - **G54.2** Cervical Root disorder, NEC not used because of Excludes 1 note
  - **S13.4xxA** Sprain of ligaments of cervical spine

How Did You Do?

Sprain but not Strain

- **M50.12** Cervical Disc Disorder with radiculopathy, mid cervical region
  - **G54.2** Cervical Root disorder, NEC not used because of Excludes 1 note
  - **S13.4xxA** Sprain of ligaments of cervical spine
  - **M62.830** Muscle Spasm, back or **M62.838** Muscle Spasm, Other

- **Y93.B3** Activity, free weights
- **Y92.39** Other specified sports and athletic area as the place of occurrence of the external cause (gymnasium)
Not Required...But Helpful

What to Do Now: Forge Ahead

What Should I Do Now?

• Concentrate on perfecting documentation
• Learn the subtle nuances in your current diagnosis protocols
• Begin to discern what each means to you

Brainstorm Operational Impact

• Computers, software, memory, other IT concerns
• Upgrades to software and testing for billing—both paper and electronic
• Super Bills, Diagnosis Sheets, Existing SOP and Training Materials

Super CAs will Contribute at a High Level
Know the IT Impact You'll Face

- What changes will need to be made?
- Do they have available upgrades?
- When will the upgrades be available?
- Upgrade and your maintenance agreement
- Will they continue to provide support?
- Parallel coding?
- How long will my system be down?

ICD-10 Organization

- Address and prioritize tasks
- Date software vendors will be compatible
- Upgrade schedules
- Readiness and testing schedules
- Training schedules for
  - Physicians
  - Office Staff

Managed Care Contracts

- Identify all your payers
- Review the policies related to ICD-9
- Reimbursements tied to diagnosis
- Modify agreements
- Determine their timelines for testing

Managed Care Contracts

- Payer policy changes = Payment impact
  - Review new payment policies
  - Improve coding and documentation
  - Communicate changes to staff
  - Dual coding
  - Know important dates

ICD-10 in My Practice

- Medicare: Free training
- Chirocode.com: free email alerts and webinars, more training, memberships, chart audits, and coding tools
- FindACode.com: Crosswalks and other advanced tools
- ICD10Monitor.com: Free Articles
- AAPC.com and AHIMA.org

Recommended Tools
FindACode.com

www.findacode.com

The Finish Line Looks Good From Here!

NOW AVAILABLE!

The KMC University ICD-9 to ICD-10 Mapping Tool

Available here or at KMCUniversity.com

(855) 832-6562