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Rhodes on the Pawtuxet

ICD-10 Survival Kit
Nancy M. Enos, FACMPE CPMA, CPC-I
On **October 1, 2015**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.”

– One implementation for all covered by HIPAA (not applicable to Automobile Insurance, Worker’s compensation, some Liability Insurance
ICD-10 Impact

• What will be affected?
  – Documentation
  – Coding
  – Charge capture
    • Lag!
  – Cash flow
    • Delay!
  – Increased denials
    • Over worked billing staff!

• What can you do?
It’s all about the Documentation

• The detail in ICD-10 depends on the information in the note-
• Coders and Billers are trained not to use “unspecified” codes-
• and are always directed to Query the Provider for more detailed information
Clinical Documentation Improvement Goals

• Identify areas in ICD-10-CM that include new terminology for clinical documentation

• Define areas in ICD-10-CM that enable improved data capture if more specific conditions are documented

• Identify how documentation affects quality measure reporting and reimbursement

• Explain how to get buy-in from all the physicians in your practice
Why is Clinical Documentation Important?

- Documentation is critical for patient care
- Serves as a legal document
- Quality Reviews
- Validates the patient care provided
- Good documented medical records reduce the re-work of claims processing
- Compliance with CMS, Tricare and other payers regulations and guidelines
- Impacts coding, billing and reimbursement
“Unspecified” Codes

• The Doctor has not given enough information in the documentation

• Differs from “Other specified” which means there is no exact code description for the documentation

• Payers will not pay a claim with an unspecified code!
Documentation Do’s

- Complete
- Legible
- Accurate
- Patient Centered
- Timely
- Concise
- Detailed
Documentation

• Improves Quality of Care
• Compliance with CMS regulations
• Drives Revenue
The Four T’s of ICD-Transition

• Timing
  – Phase I and Phase II
• Training
  – Identify training needs by role
• Technology
  – Evaluate tools that can mitigate financial risk of the ICD-10 transition
• Testing
  – New technology also can boost productivity to help offset the losses that occur during and after the transition
Comparison of ICD-9 to ICD-10
Reimbursement and Quality Problems with ICD-9

• Example – fracture of wrist
  Patient fractures left wrist

• A month later, fractures right wrist
  – ICD-9-CM does not identify left versus right –
    • requires additional documentation
  – ICD-10-CM describes
    • Left versus right
    • Initial encounter, subsequent encounter
    • Routine healing, delayed healing, nonunion, or malunion
# Comparison of Code Sets

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters</td>
<td>3-7 characters</td>
</tr>
<tr>
<td>More than 17,000 codes</td>
<td>More than 155,000 codes</td>
</tr>
<tr>
<td>First digit may be alpha or numeric (E or V only), digits are 2-5 are always numeric</td>
<td>First character is alpha; 2 &amp; 3 are numeric; 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible, new format allows for expansion</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Includes a specific field to identify laterality (right vs. left)</td>
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</table>
ICD-10 Changes Everything

Detailed Clinical Information

- Episode of care
- Laterality
- Severity

ENOS Medical Coding
ICD-10 Differences

- Combination Codes
- Laterality
- Episode of Care
- Exact Anatomic Location
- Clinical Details
- Cause/etiology
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication
  – Simplifies the number of codes needed to clinically spell out a condition
  – *Documentation will need to support all elements*
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
    K71.51 Toxic liver disease with chronic active hepatitis with ascites

• What additional documentation will be needed?
  - Chronic, acute, subacute, persistent
  - Active, Lobular, fibrosis, cirrhosis, necrosis
  - With or without coma
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication

E11.21 Type 2 diabetes mellitus with diabetic nephropathy

What additional documentation will be needed?

- Hypersmolarity, □ with coma, □ with kidney complications, □ nephropathy, □ with CKD, □ with ophthalmic complications, □ neuropathy, □ circulatory complications, □ skin complications, □ arthropathy, □ oral complications
Laterality

- Code descriptions include designations for left, right and in many cases bilateral
- Documentation should always include laterality
- What additional documentation will be needed?
  - Right
  - Left
  - Bilateral
Laterality- Left versus Right

• C50.111 Malignant neoplasm of central portion of right female breast
• C50.112 Malignant neoplasm of central portion of left female breast
• C50.119 Malignant neoplasm of central portion of unspecified female breast

• Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.
Example:

- H61.12 Hematoma of pinna
  - H61.121 Hematoma of pinna, right ear
  - H61.122 Hematoma of pinna, left ear
  - H61.123 Hematoma of pinna, bilateral ears
  - H61.129 Hematoma of pinna, unspecified ear

- What additional documentation will be needed?
  - Right
  - Left
  - Bilateral
ICD-10 Structure

• The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity

• Characters 1-3 - Category ("Block")

• Characters 4-6 - Etiology, anatomic site, severity, or other clinical detail

• Character 7 – Extension (example- episode of care or other clinical detail)
Fifth/Sixth Characters

• **Identifies the most precise level of specificity**

• **Example:**
  
  – S55.011- Laceration of ulnar artery at forearm level, right arm

3 - S55 is a category for injury of blood vessels at forearm level
4 - S55.0 specifies the injury is at the **ulnar artery** at the forearm level
5 - S55.01 specifies it is a **laceration**
6 - S55.011 specifies it is of the **right arm**

• **A 7th character extender is also required**
Seventh Character Extenders

Examples:

A – Initial Encounter
D – Subsequent Encounter
S – Sequela - complications or conditions arising from the injury

What additional documentation will be required?

- Initial care (document active care)
- Subsequent care (document follow up or after care)
- Sequela (Provider must state the relationship is a late effect or residual effect)
Detailed Example

• S52 Fracture of Forearm
• S52.5 Fracture of lower end of radius
• S52.52 Torus fracture of lower end of radius
• S52.521 Torus fracture of lower end of right radius
• S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
A unique twist- the “Placeholder”

• Some codes are 7 characters, but no 4th, 5th or 6th place is necessary, so “x” is a placeholder

• T68.xxxA  - Hypothermia

• The appropriate 7th character is to be added to code T68

• A – initial encounter

• D – Subsequent encounter

• S – sequela
ICD-10 CM 21 Chapters

1. Infectious and Parasitic Diseases
2. Neoplasm’s
3. Diseases of the Blood and Blood-Forming Organs
4. Endocrine, Nutritional and Metabolic Diseases
5. Mental and Behavioral Disorders
6. Disease of the Nervous System
7. Diseases of the Eye and Adnexa
8. Diseases of the Ear and Mastoid Process
9. Diseases of the Circulatory System
10. Diseases of the Respiratory System
11. Diseases of the Digestive System
12. Diseases of the Skin and Subcutaneous Tissue
13. Diseases of the Musculoskeletal System and Connective Tissue
14. Diseases of the Genitourinary System
15. Pregnancy, Childbirth and the Puerperium
16. Newborn (Perinatal)
17. Congenital Malformations, Deformations and Chromosomal Abnormalities
18. Symptoms, Signs and Abnormal Clinical and Laboratory Findings
19. Injury, Poisoning and Certain Other Consequences of External Causes
20. External Causes of Morbidity
21. Factors Influencing Health Status and Contact with Health Services
Diabetes Mellitus

There are five (5) Diabetes Mellitus categories in the ICD-10-CM to reflect the current clinical classifications of diabetes. They are:

• E08  Diabetes Mellitus due to an underlying condition
• E09  Drug or chemical induced diabetes mellitus
• E10  Type I diabetes mellitus
• E11  Type 2 diabetes mellitus
• E13  Other specified diabetes mellitus
Diabetes Mellitus

• Combination codes are used in ICD-10-CM for diabetes

• The three character category shows the type of diabetes

• The fourth character shows the underlying conditions with specified complications

• The fifth character defines the specific manifestation
Diabetes Mellitus

• ICD-9-CM has fifth-digit sub classifications that state the type of diabetes (including unspecified) and whether the diabetes is uncontrolled or not stated as uncontrolled
  - 250.00  Diabetes without mention of complication, NOS, not stated as uncontrolled

• ICD-10-CM has no stated unspecified code, so the default is type II and no longer classified as uncontrolled/ controlled
  - E10.11  Type 1 diabetes mellitus with ketoacidosis with coma
Type of Diabetes

• The age of a patient is not the sole determining factor, though most Type 1 diabetics develop the condition before reaching puberty.

• For this reason Type 1 diabetes mellitus is also referred to as juvenile diabetes.

• E10 Type 1 diabetes mellitus
Overweight, obesity and other hyperalimentation (E65-E68)

• Understanding BMI will help you to determine the parameters of the difference between overweight and obesity.

• BMI (use this as an additional code to identify body mass index (BMI) if known Z68.-)

• Underweight    Below 18.5
  Normal         1.8.5-24.9
  Overweight     25.0-29.9
  Obesity        30.0 and Above
Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

• Pain disorders related to psychological factors
• Mental and behavioral disorders due to psychoactive substance abuse
Headaches

• Symptoms that signal the onset of a migraine are used to describe two types of migraine.
  – Migraine with aura (known as "classic" migraine)
  – Migraine without aura (known as "common" migraine)

• Status migrainosus refers to a rare and severe type of migraine that can last 72-hours or longer. The pain and nausea are so intense that people who have this type of headache often need to be hospitalized. Certain medications, or medication withdrawal, can cause this type migraine syndrome.
Chronic/Persistent

• **Chronic migraines** are classified by the International Headache Society as a migraine that occurs greater than 15 days per month for at least 3 months.

• **Persistent migraines** are migraines that last more than three months and occur daily from within three days of onset.
Chapter 8: Diseases of Ear and Mastoid Process (H60-H59)

- Chapter contains blocks: This chapter contains the following blocks:
  - H60-H62: Diseases of external ear
  - H65-H75: Diseases of middle ear and mastoid
  - H80-H83: Diseases of inner ear
  - H90-H94: Other disorders of ear
  - H95: Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

  - *The codes for reporting Complications of Surgical and Medical Care were reported in Chapter 17 in ICD-9 under Injury and Poisoning. In ICD-10 these codes are found in the system they relate to*
Acute/Chronic

• **H66.0 Acute** suppurative otitis media is a sudden, severe inflammation of middle ear, with pus.

• **H65.2 Chronic** suppurative OM is a chronic inflammation of the middle ear that persists at least 6 weeks and is associated with otorrhea through a perforated TM, an indwelling tympanostomy tube, or a surgical myringotomy.

• Document **right, left, bilateral**

• Document **Recurrent, acute, subacute allergic**
Chapter 9: Diseases of Circulatory System (I00-I99)

• Coronary heart disease, also called coronary artery disease, is a condition in which plaque builds up inside the coronary arteries. It is the most common type of heart disease. These arteries supply oxygen rich blood to your heart muscle.

• Plaque is made up of fat, cholesterol, calcium, and other substances found in the blood. When plaque builds up in the arteries, the condition is called atherosclerosis. The buildup of plaque occurs over many years.
Angina

• A common symptom of coronary heart disease (CHD) is angina.
  • Angina is chest pain or discomfort that occurs if an area of your heart muscle doesn't get enough oxygen-rich blood.

• I20.- Angina Pectoris

• What additional documentation is needed?
  - Unstable
  - With documented spasm
  - Other forms of angina pectoris
Shortness of Breath

- Another common symptom of CHD is shortness of breath. This symptom happens if CHD causes heart failure. When you have heart failure, your heart can't pump enough blood to meet your body's needs.
- R06.02 Shortness of Breath
- What additional documentation is needed?
  - Dyspnea
  - Orthopnea
  - Stridor
  - Hiccough
  - Wheezing
  - Hyperventilation
  - Periodic breathing
  - Sneeze
Ischemic Heart Disease

- ICD-10-CM separates codes for ischemic heart disease by the type of vessel affected, as well as if the patient is also experiencing angina.
- Coronary artery disease (CAD) also known as atherosclerotic heart disease, coronary heart disease, or ischemic heart disease (IHD), is the most common type of heart disease and cause of heart attacks.
- The disease is caused by plaque building up along the inner walls of the arteries of the heart, which narrows the arteries and reduces blood flow to the heart.
Hypertension I10

• There is no hypertension table found within ICD-10-CM as it is no longer necessary.
• Codes have been simplified and many combination codes have been created in this chapter.
Hypertension with Heart Disease

- Heart conditions classified to I50.- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease, when a causal relationship is stated (due to hypertension) or implied (hypertensive).

- Use an additional code from category IS50, Heart failure, to identify the type of heart failure in those patients with heart failure.

- The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately.

- Sequence according to the circumstances of the admission/encounter.
Example

• A patient visits his cardiologist for his 3 month follow-up visit. He is being treated by the cardiologist for **hypertensive heart disease with benign hypertension**.

• I11.9 Hypertensive heart disease without heart failure

• What additional documentation is needed?
  - With Heart Failure
  - Without Heart Failure
Hypertensive Chronic Kidney Disease

• Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present

• Unlike hypertension with heart disease, *ICD-10-CM presumes a cause and effect relationship* and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.
Hypertensive Chronic Kidney Disease

- Use an additional code to identify the type of heart failure (I50.-)
- Use additional code to identify stage of Chronic Kidney Disease (N18.1-N18.4, N18.9)

- What additional documentation is needed?
  - Type of heart failure
  - Stage of Chronic Kidney Disease
Acute Myocardial Infarction (AMI)

The coronary arteries supply blood and oxygen to the heart. If the blood flow is blocked long enough, a portion of the heart muscle is damaged or dies. This condition is a myocardial infarction (MI), or heart attack. More than a million people each year in the United States suffer MIs. The site of the MI will reflect the coronary artery experiencing the ischemia. For example, an MI of the anterior wall is caused by ischemia in the left anterior descending coronary artery.
4 week Rule

• Coding of myocardial infarctions is different in ICD-10-CM. In ICD-9-CM, MI’s are coded as acute and chronic, utilizing an 8 week rule as a guide.

• In ICD-10-CM, MI’s are coded as initial and subsequent, utilizing a 4-week rule.
Coding for AMI

- The ICD-10-CM codes for acute myocardial infarction (AMI) identify the **site**, such as anterolateral wall or true posterior wall.
- Subcategories I21.0-I21.2 and code I21.3 are used for **ST elevation myocardial infarction (STEMI)**.
- Code I21.4, **Non-ST elevation (NSTEMI)** myocardial infarction, is used for **non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs**.
Diseases of the Respiratory System

• J01 Acute Sinusitis is coded by location
  – Maxillary, Frontal, Ethmoidal, Spyhenoidal, Pansinusitis
  – 5th character designates **Acute** or **Acute Recurrent**

• J32 Chronic Sinusitis
  – Maxillary, Frontal, Ethmoidal, Spyhenoidal, Pansinusitis
  – Use additional code to identify exposure to environmental tobacco smoke Z72.22
Asthma

- Asthma is a chronic lung disease in which the airways narrow and swell and produce extra mucus. It affects more than 25 million Americans. Asthma symptoms include coughing, wheezing, shortness of breath, and chest tightness. Asthma cannot be cured, just controlled.

- Coding for asthma has greatly expanded in ICD-10-CM to include *intermittent, mild persistent, moderate persistent and severe persistent.*
Diseases of Esophagus, Stomach and Duodenum (K20-K31)

• There are certain codes in this subcategory that require the use of an additional code to identify alcohol abuse and dependence (F10-) and additional documentation will be required in order to meet this level of specificity.

• If the note documents the use of alcohol as a cause of disease of the Esophagus, Stomach and Duodenum, use an additional code from F10 to identify the alcohol use and dependence

• **What additional documentation is needed?**
  - Alcohol use, abuse or dependence
EXAMPLE:

- Tim is being seen in treatment today due to vomiting with traces of blood. He has been a long time alcoholic and on a recent drinking binge. After endoscopy the surgeon notes he has Barrett's ulcer with hemorrhage exacerbated by his alcohol dependence.
  - **K22.11** Ulcer of esophagus with bleeding
  - **F10.20** Alcohol dependence without complication
Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)

• New ICD-10-CM Documentation Elements Related to Digestive System Coding
  – Pressure ulcers
    • One code reports site and stage
    • More specific bilateral codes
    • Separate codes for abscesses and cellulitis
    • Separate codes for furuncle and carbuncle
    • Laterality
Skin and Subcutaneous Tissue

- New ICD-10-CM Documentation Elements Related to Integumentary System Coding
  - Contact dermatitis
    - Allergic
    - Irritant and substance cause
  - Burns
    - Identified by cause (e.g., heat, chemical)
    - Episode of care required
  - Pressure Ulcers
    - Decubitus ulcers
    - Bedsores
    - Bedridden patients
    - Stages I - IV
A 25-year-old male was working late at a mechanic’s garage when a robber came in to steal tools. The patient confronted the robber, who in turn threw battery acid on the patient and fled. The patient presented to the ED with battery acid burns on his chest by the collarbone, and had symptoms of redness, irritation, blisters, pain and numbness. The area of the burn was flushed with cold water and wet compresses were used to ease the pain. It was wrapped in a dry, sterile cloth. An antibiotic was given and the patient was told to follow-up with his regular physician for dressing changes.

Code(s):
- ICD-9-CM 942.32, 948.00, E961, E849.3, E000.0, E029.9
- ICD-10-CM T54.2x3A, T21.71xA, T32.0, Y92.59, Y93.89, Y99.0
Pressure Ulcers

- Pressure ulcers are coded by stages.
- Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.

- What additional documentation is needed?
  - Exact location
    - Elbow (right or left)
    - Back (right upper, left upper, left lower, right lower)
    - Sacral region
    - Hip (right hip or left hip)
    - Buttock (right buttock or left buttock)
    - Contiguous site (back, buttock and hip)
    - Ankle (right ankle, left ankle)
    - Heel (right heel, left heel)

  - Stage (Stage 1 through Stage 4 or Unstageable due to eschar)

  - Note: Unstageable is not “Unspecified”
Unstageable Pressure Ulcers

- Assignment of the code for unstageable pressure ulcer should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.

- This code should not be confused with the codes for unspecified stage (L89.9-). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.9-).
Non pressure ulcers due to underlying conditions

- Additional codes are necessary to fully describe the patient's condition for non-pressure chronic ulcers in ICD-10-CM. There are instructional notes under category L97 that state to code first any associated underlying conditions, such as atherosclerosis of the lower extremities, chronic venous hypertension, diabetic ulcer, or varicose ulcer. There is another note that states to code first any associated gangrene. The provider's documentation will drive what codes are able to be assigned.

- Non pressure ulcers are caused by underlying conditions. Code first the underlying condition as long as the provider has documented the relationship.
Example

• May is a type 2 diabetic. She presents to the office today with a diabetic ulcer on her left great toe. May does not inspect her feet on a daily basis, but does check them about once a week. The breakdown of the ulcer is limited to the skin.
  – E11.621 Type 2 diabetes mellitus with foot ulcer
  – L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

• The musculoskeletal Chapter contains approximately 60% of the codes in ICD-10. The expanded codes are due to the increased specificity in anatomic locations, laterality, episode of care, and cause codes.
• Injuries (fractures) are reported in Chapter 19
Arthritis and Osteoarthritis

- Arthritis and osteoarthritis have both site and laterality designations in ICD-10-CM. It also includes the type of arthritis such as
  - primary,
  - secondary or
  - post-traumatic.
Example

- A patient is treated by an orthopedic surgeon for primary osteoarthritis of the right knee. The patient complains of chronic knee pain that worsens at night. The physician prescribed an anti-inflammatory drug to relieve the pain.
  - M17.11 Unilateral primary osteoarthritis, right knee
Urology/Gynecology

- Female disorder found in this chapter include pelvic inflammatory diseases, female infertility, and menopausal and perimenopausal disorders. Disorders of the breast (excluding those associated with childbirth) are also located in this chapter.
- Many of the Urology issues found in Chapter 15 are treated by gynecologists.
Male Urology Example

• Jack presents to the office today complaining of having to get out of bed at night repeatedly to urinate. He has previously been diagnosed with BPH. After history and exam today his diagnosis is BPH with nocturia.
  – N40.1 Enlarged prostate with lower urinary tract symptoms
  – R35.1 Nocturia
Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.
Use of Symptom Codes

• Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
  – Never use a definitive diagnosis code when the documentation includes phrases such as “Rule out, Question of, Suspected or Probable”.
  – Code the signs and symptoms unless there is a definite diagnosis
Example

- A patient visited his family physician with symptoms of nausea and vomiting. The symptoms began two days ago. The patient has no other symptoms. The physician examines the patient and prescribes medication to help with the condition.
  - R11.2 Nausea with vomiting, unspecified
Use of a Symptom Code with a Definitive Diagnosis Code

• Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.

• The definitive diagnosis code should be sequenced before the symptom code.

• Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
Chapter 21 Factors Influencing Health Status and contact with Health Services

• Z Codes Indicate a Reason for an Encounter

• Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed.

• For example, Z23 Encounter for immunization, requires a procedure code to identify the type of immunizations given.
Inoculations and Vaccinations

• Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given.

• Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.
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 (eg, 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.
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 may require continued monitoring. Voice memo 7/16/13 Part 1
  – 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.
Physicians Get Ready!

- Become familiar with the new details ICD-10-CM will require in your notes
- Review crosswalks of your most frequently used ICD-9 codes
- There will be a “One to Many” crosswalk—don’t depend on a simple encounter form
- Many Denials and Delays can be avoided with training and good documentation!
Question & Answer Session
About the Speaker

Nancy M Enos, FACMPE, CPC-I, CPMA, CEMC is an independent consultant with the MGMA Health Care Consulting Group. Mrs. Enos has 30 years of operations experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice.

As an Approved PMCC Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-9 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including State and Sectional MGMA conferences, and hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives and serves as a College Forum Representative for the American College of Medical Practice Executives. She is on the Section Council for MGMA and is a Past Chair of the Eastern Section, and a Past President for MA/RI MGMA.