**CMS-AAPC ICD-10 Code-a-thon - Sept 15th 2014 Questions & Answers transcript**

*Disclaimer: AAPC’s expert coders interpreted and applied ICD-10 guidelines and best practices to answer questions during the code-a-thon. The content of this presentation does not necessarily reflect CMS policy. It is not always possible to provide definitive answers about specific coding scenarios without access to the complete clinical documentation and medical record.*

Question:

What is correct complication dx code for post-tonsillectomy hemorrhage?

Answer:

The codes for complications in ICD-10-CM are listed under their respective organ systems. The tonsils are considered part of the respiratory system in ICD-10-CM, and the codes for intraoperative and postprocedural complications of the respiratory system are located under category J95. Code J95.61 is for Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating a respiratory system procedure.

Question:

If documentation as OA of hands, feet, back and knees can we code M15.9, polyosteoarthritis, unspecified or should we code for each site?

Answer:

Category M15 includes arthritis of multiple sites. M15.9 would be used if the type of arthritis is not indicated in documentation. M15.9 includes generalized osteoarthritis NOS

Question:

What is correct root operation for septoplasty-excision or repair or reposition?

Answer:

In ICD-10-PCS the root operation is the main objective of the procedure. A general term like septoplasty could be any of the terms you listed under ICD-10-PCS.

Question:

When placing a pancreatic stent should this be coded to insertion or dilation?

Answer:

In ICD-10-PCS the main objective of the procedure is chosen as the root operation. For stent placement, the root operation would depend on the reason it was placed and whether it remains when the procedure is completed. It may be either an insertion or dilation.

Question:

When a patient is seen initially for an injury in an ED, the emergency room doctor codes the injury with an “A” 7th character. If the ED doctor refers the patient to a orthopedist for follow-up care, the specialist codes the injury with a “D” subsequent encounter even though a) this is the first time the patient is seen by the specialist for the condition, b) even though follow-up care for the condition could be considered routine care during the healing or recovery phase of the injury that was previously seen by a different (unrelated) physician, and c) if a patient with a new condition is seen by a specialist, it is the responsibility of the specialist’s office to find out if another physician had seen the patient prior (hence the referral) and that “active” treatment was rendered.

1. It is my understanding that even though the ED physician doesn’t initiate definitive treatment for the patient’s condition/injury, but palliatively stabilizes it for referral, the event when the specialist sees the patient for the first time for the condition is still considered “subsequent”, correct?

2. If a patient sees their family doctor for an injury, and the family physician – who may not have the expertise or skills to handle the problem – refers the patient to the specialist after applying a bandage or dispensing crutches, the same 7th character coding – “D” – would be used by the specialist seeing the referred patient even though this is the initial encounter for the condition for the specialist, correct?

Answer:

Remember that A is not only for "initial", the guidelines state active care. 19.a lists examples of active care, such as surgical treatment, ED encounter and evaluation and management by a new physician.

Question:

What dementia codes should we stop using now in preparation for ICD10?

Answer:

Codes do not need to be discontinued for ICD-9. The type of dementia will important to be included in documentation under ICD-10-CM. Examples of types would be degenerative or Alzheimer's type. Documentation should also include associated conditions, such as behavior disturbances.

Question:

Will there be 2015 ICD-10-CM Official Guidelines for Coding and Reporting or will we be using 2014 version next year?

Answer:

We are currently in a code set freeze. You can access the 2015 guidelines on the CDC website but there were no changes.

Question:

When will the coding clinics be updated for ICD-10?

Answer:

Coding clinic will not be updated. The Cooperating Parties have determined that it would not be very useful to convert old Coding Clinics to ICD-10. Instead, we launched providing ICD-10 advice in the 4th Quarter 2012 issue of Coding Clinic for ICD-9-CM. http://www.ahacentraloffice.org/codes/products.shtml#CCICD10

Question:

How should it be coded if the physician states "smokes" one pack a day (or any quantity)? CC4Q2013 pg. 108 only talks about the diagnosis of "smoker" in order to code F17.200. Without smoker does it default to tobacco use?

Answer:

It would be up to the provider’s clinical determination. Best practices would be for you to have written criteria or references that you obtain from your physician.

Question:

Our agency is approaching the ICD-10 implementation from a very different perspective, e.g., our E.H.R. will contain "SNOMED" clinical terms which the provider will select for their diagnoses and the SNOMED codes will, for the most part, map to the ICD-10 codes. Then it will be up to our coders to code the correct ICD-10 codes. Providers will not learn about ICD-10, what is your expert opinion of this approach.

Answer:

Practices must do what they feel is best for the transition. Documentation will be key no matter what reference used.

Question:

The appropriate 7th character is required for category S33. When a doctor of chiropractic is rendering services for a sprain injury and providing initial treatment, would this best be described as "A" initial encounter; even if treatment spans 2-3 weeks during the initial active treatment plan? How can a provider obtain more information as to how CMS will define what is considered "initial encounter' and what is considered "subsequent encounter" when it applies to spinal manipulation for an injury related diagnosis? Is there information available from major payers on how they will interpret the 7th character "A" and "D"?

Answer:

According to the 2014 Official Draft Guidelines for ICD-10-CM (I.C.19.a), the 7th character A is assigned while the patient is receiving active treatment for the condition. The examples given are surgical treatment, emergency department encounter, and evaluation and treatment by a new physician. 7th character D is assigned after the patient has received active treatment and is receiving routine care for the condition during the healing and recovery phase.

You will need to watch CMS and commercial plans websites for their perspective on the 7th character externders.

Question:

Say, currently we report everything in icd9 codes. And if it wanted to start trying reporting in icd10, where can I find the mappings from icd9 to icd10?

Answer:

AAPC offers "fast forward" mappings that include the top 50 in each specialty. We also do custom mapping. https://www.aapc.com/ICD-10/icd-10-mapping.aspx

Question:

How do we deal with "the boy who cried wolf" syndrome?

Answer:

I suggest taking the word ICD-10 out of the conversation if needed, instead speak to documentation regarding other initiatives you have to meet such as PQRS, quality incentives, disease management tracking and such. Once you have completed that a diagnosis code is no longer the issue, meaning it simply blends in with all else that you do.

Question:

Could you repeat please the website where there were free ICD-10 mapping files? Thank you!

Answer:

Here you go: http://www.aapc.com/ICD-10/crosswalks/pdf-documents.aspx

Question:

Is there an online ICD-10 coding class I can take?

Answer:

AAPC offers an online coding class for both ICD-10-CM and ICD-10-PCS and will be running a back to school sale later this week, offering discounts. https://www.aapc.com/ICD-10/training.aspx

Question:

Is there an ICD-10 code for Dx of unknown etiology I.E. Dx of residents that are admitted to SNF for 10+ years if no documentation was obtained prior?

Answer:

Can you provide additional information about your question - would documentation include signs or symptoms? Why is the reason for the encounter?

Question:

What is the PCS root operation for Fetal EKG via scalp electrodes? Are we using Insertion or Monitoring or both?

Answer:

It would be considered a Monitoring as that is the objective of the procedure.

Question:

Do you recommend abandoning use of the old handwritten "superbill" once ICD-10 is implemented? Even though we are a specialist's office, the number of diagnosis codes that we would need to include would change our 1 page document to approx. 11 pages. Do you have any suggestions on how to ease our providers into this?

Answer:

It will be harder to accomplish without providing the physician a tool to accompany it. My suggestion would be to crosswalk your most frequently used codes now and provide them with a tool that is handy for them to reference; otherwise, chances are they will not write enough information to capture the codes.

Question:

We are struggling on how to direct our providers when to assign the seventh character of "A"

Per ICD 10 coding guidelines:

7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

What qualifies as an evaluation and treatment by a “New Physician”? Only specialties qualifying as MD/DO or does this include other ancillary providers? (Clarify PT/OT/SLP)

Clarify: receiving active treatment for the condition. If the condition has already been evaluated by an MD, and an order is written for PT- Is PT considered active treatment? Post surgically? In chronic muscular conditions?

For first PT visit when plan of care is developed?

Answer:

There are no clear guidelines at this time; we are hoping to receive further clarification. This is yet another example as to why groups that represent physicians should be included on the C&M committee.

Question:

How much will Physical therapy be affected with the transition to ICD-10?

Answer:

Physical therapy will have larger impacts due to the expansion of injury and musculoskeletal codes.

Question:

If our software provides a crosswalk from ICD 9 to 10, will that be sufficient for coding?

Answer:

You must check to see where they got their final result. If they only provided mapping via the GEMs files then you will not have complete files. Also, if you used a lot of unspecified codes in ICD-9-CM you will want to take a look at more specific codes in ICD-10-CM.

Question:

When will you have live Seminars for people to attend?

Answer:

It is available now. https://www.aapc.com/ICD-10/training.aspx

Question:

If a patient has a back injury due to lifting something, how would you additionally describe that?

Answer:

The activity, location and work status of the patient (if initial encounter).

Question:

Is the finalized ICD-10 code book going to be available?

Answer:

The draft is available and will become "finalized" upon implementation of the codes. https://www.aapc.com/medical-coding-books/icd-10-books.aspx

Question:

Does AAPC require membership before accessing the free resources mentioned?

Answer:

No, we do not require membership for many free resources. If you go to this link https://www.aapc.com/ICD-10/icd-10-codes.aspx you will find many resources that you can use to assist in the implementation of ICD-10, including quick reference guides, ICD-10 newsletters, and links.

Question:

What is the difference between M17.31 post-traumatic arthritis right knee and M12.561 traumatic arthropathy right knee?

Answer:

Arthritis is an inflammation of the joint, which is a type of arthropathy, the general term used to denote diseases/conditions of the joint. Arthropathy could affect a single joint, as in traumatic arthritis, or multiple joints, as in rheumatoid arthritis. Documentation should be specific as to the type of joint condition in order to assign a more specific code.

Question:

What is the correct way to code for arthritis when the documentation states only "arthritis, left shoulder"?

Answer:

Documentation for arthritis should indicate the type - primary, secondary, post-traumatic. When the site id documented without the type, the specificity of the site (shoulder) is lost in the code selection. M19.90 is the default code for Arthritis, NOS and osteoarthritis, NOS.

This is an opportunity for documentation improvement.

Question:

Our providers, particularly in the Pain, Neuro, and Ortho specialties, have noticed that some codes that they expect laterality codes do not always have these available as they expect. This seems most common for spinal conditions. How should they a.) Document laterality for such codes, and b.) Report the omission to CMS for consideration to be added later?

Answer:

Laterality is important even though not indicated in the coding selection. We have noticed this as well. If you go to the CDC website you can report and request. http://www.cdc.gov/nchs/icd/icd10cm.htm

Question:

Will there be any changes/modifications/updates to the LCD/NCD codes for coverages, for instance, Vitamin B-12 that you know of?

Question:

Can you please explain the difference between initial encounter and subsequent encounter? For example, if a fracture was set/casted by a primary care, but then they were sent to Ortho for follow up, would that Ortho visit be an initial encounter because it is a new specialty or is it subquent since they have already been seen by a provider?

Answer:

You would use A for any active treatment, in the absence of clear guidelines it would be up to the provider’s clinical determination.

Question:

How much time do you suggest coders "practice" ICD-10 before 10-1-15?

Answer:

We believe at least 3-4 months is needed for productivity levels to rise.

Question:

For nonunion, malunion, and delayed healing of fractures is treatment always considered "subsequent encounter" and what is the rationale?

Answer:

No, there are separate 7th character extenders for nonunion, malunion and delayed healing.

Question:

What is the best way to prepare for the ICD-10 certification?

Answer:

Study the guidelines and instructional notes.

Question:

Assuming that clinical documentation supports a billed diagnosis code and that the billed diagnosis code is correct, must the clinical diagnosis be explicitly stated in the medical record for compliant billing? Or instead can the billed diagnosis be appropriately inferred from the supportive documentation in the medical record?

Answer:

Clinicians do not document in coding terms, they document in clinical terms, and therefore I would never expect to see a diagnosis descriptor fully written out in a medical record.

Question:

Can we see examples of HTN, different levels of diabetes, coronary disease, etc.? Someone mentioned there was a different process to code now, can this be shown as well?

Answer:

There is no longer a hypertension table found in ICD-10-CM, this somewhat simplifies the coding for this condition. For others there are now combination codes that help capture manifestations and complications of disease processes.

Question:

What would be a good way to show surgeons the need for documentation for ICD-10?

Answer:

Perform documentation audits and show them where they may be missing key pieces of documentation.

Question:

Is it advisable to purchase a computer assisted coding (CAC) tool to help with the new coding requirements?

Answer:

CAC is great, as long as the person using it has been trained well in the coding system.

Question:

With the laterality being added into many of the ICD-10 codes will the lateral modifiers be going away? If laterality is being coded with the diagnosis will it still need to be reported with a modifier on the CPT as well?

Answer:

The modifier -50 is not going away at this time, although we continue to work with health plans to eliminate it due to redundancy.

Question:

Would it be beneficial to have an ICD-10 physician champion help with the other physicians in the facility?

Answer:

Yes, absolutely.

Question:

Is diskectomy additionally coded in PCS when an anterior spinal fusion with cages is performed or is it considered inherent to the fusion procedure?

Answer:

As the main objective of the procedure is the fusion, the diskectomy would be inherent to the procedure.

Question:

Gestestional age for pregnant patients. When should this code be added? I seem to have gotten different opinions. I was told only with complications, others are saying to add even with the code for the normal pregnant code.

Answer:

The instructional notes only state to use an additional code from Category Z3A , Weeks of gestation, to identify the specific week of gestation, it does not indicate only for complications.

Question:

What is the biggest change for the front office staff and our MA’s? What training should we supply them with?

Answer:

Any changes you make to participation with health plans, any changes made to forms, ABNs, diagnostic and such.

Question:

Now that there is one ICD-10 code for all vaccines, how do I bill for all administration of vaccines on the same day of visit without being wrongly denied for duplicated claims?

Answer:

You should not be denied, as you will have CPT codes to correspond.

Question:

In preparation for ICD10, there really is not enough training for all specialties, particularly Neurosurgery. Can we look forward to AAPC adding specific information for this specialty?

Answer:

Yes, continue to watch our website.

Question:

Will RT and/or LT modifiers still need to be appended to CPT codes if we are assigning a diagnosis code that indicates laterality? Last I had heard we still do, but I wanted to know if there have been any changes to that. Thank you.

Answer:

Modifiers will not be going away with the new codes. We continue to try and work with health plans to try and get this redundancy changed.

Question:

How will ICD-10 impact V codes and specially screening colonoscopy (G0121/G0105) coding and reimbursement?

Answer:

There should be no changes.

Question:

Can you provide a resource/website of who to inform/report, if we find a conflict of Excludes notes or coding conventions?

Answer:

http://www.cdc.gov/nchs/icd/icd10cm.htm you can report them here. We have reported many as we find them.

Question:

As a medical coding student, I would like to engage in simulated "hands on" dual coding for the 2015 I10 transition. What resources can our presenters/coders recommend? Thank you

Answer:

Check with your local AAPC chapter to see if they have internships available. In addition we have Practicode cases available for purchase on the AAPC website.

Question:

Where can we get the list of the most commonly used DX for primary care physicians? I attended a seminar last year with BC/BS, and they were able to put together a list for us to look at. Do you have something similar to that effect?

Answer:

AAPC offers "fast forward" mappings and it includes the top 50 codes for each specialty. https://www.aapc.com/ICD-10/icd-10-mapping.aspx

Question:

As a billing service, besides employee training and verification with vendors, what should we focus on for successful ICD-10 implementation?

Answer:

Testing is key.

Question:

Recognizing that particular codes and payment are the decision of the payers, are R- and Z- codes going to be like V- codes were in ICD-9. That is, if you put these on your billing sheet in the first position, the entire claim was denied. Should be avoid putting an R- or Z code as the principal diagnosis?

Answer:

The coding guidelines indicate the use of these codes from these categories is acceptable. Chapter 18 specific guidelines - Signs and Symptoms - are acceptable for use when a definitive diagnosis is not available. General coding guidelines also state that it is acceptable to report signs and symptoms in the absence of a definitive diagnosis. The Z codes for Factors influencing Health Status and Contact with Health Services provide symbols at the right of the codes that indicate when this code is acceptable for a primary diagnosis.

Question:

Knowing A&P has always been important as a Coder. Could you please clarify why knowing A&P has been emphasized more with the implementation of ICD-10CM? Thank you!

Answer:

Because of the higher level of specificity the anatomical location is now part of the coding selection as well as more specific clinical conditions.

Question:

Is there a way to capture C-section with vacuum assist in PCS?

Answer:

I apologize, but I need further clarification of your question. Are you asking if a vaginal vacuum assist is converted to a C-section?

Question:

Will there be a special session for specialist such as chiropractic’s?

Answer:

AAPC does not have one at this time but continue to check our website.

Question:

Well child code. There are well child care codes with abnormal findings and one with out. What is classified as an abnormal finding? For example: Patient comes for a well child visit and a has an ear infection. Would this be coded as "with abnormal findings" or not?

Answer:

A finding would be upon exam, so if the provider did not know the patient had an ear infection prior to the exam you would use with abnormal findings. Without seeing the documentation that includes work involved it is not possible to answer definitely.

Question:

We have a 2011 ICD-10 Complete Official Draft Code Set book, will we need to buy a new one and if so, when will it be available?

Answer:

Yes, you need a new book to learn, there were many changes in 2012.

Question:

What was the site with the mappings?

Answer:

https://www.aapc.com/ICD-10/icd-10-mapping.aspx

Question:

Re: Complication dx code for post-tonsilllectomy hemorrhage...would it be Y83.6?

Answer:

Code Y83.6 is a secondary code that would be used to indicate that the complication was not a misadventure.

Question:

Where can we find specific specialty ICD10 coding on website and how?

Answer:

AAPC offers "fast forward" mappings and it includes the top 50 codes for each specialty. <https://www.aapc.com/ICD-10/icd-10-mapping.aspx>

Question:

I purchased 2012 ICD-10 CM "Draft" books - are these still correct to use and train with?

Answer:

Yes

Question:

What ICD 10 book is recommended for physician practices to use? Where do I purchase?

Answer:

AAPC offers "fast forward" mappings and it includes the top 50 codes for each specialty. <https://www.aapc.com/ICD-10/icd-10-mapping.aspx>

Question:

Do you need to be an AAPC member to access the free resources mentioned in the presentation?

Answer:

No, you do not need to be a member.

Question:

I work at a bariatric office. We used ICD 9 code 278.01 for all of our patients and of course we ad their comorbidity. Will the morbid obesity code change or will it still be 278.01

Answer:

The structure of all diagnosis codes will change with ICD-10-CM. Obesity codes are located in Category E66 and include overweight and obesity based on the type or cause of the obesity. An instructional note states to use an additional code to identify BMI, if known.

Question:

SHOULD PHYSICIANS START GETTING IN THE HABIT OF DOCUMENTING LEFT AND RIGHT OR BILATERAL

Answer:

Yes, that should already be a part of documentation, regardless of the coding system.

Question:

Is there a vocabulary list for each of the categories = anatomy, locality, laterality so as not to cross over when coding?

Answer:

Not that I am aware of.

Question:

In ICD-9 what would you have coded for a "well child visit" if that child wound up having a cold or flu? It wouldn't be considered a "well child visit" would it? Wouldn't you have coded it to the symptom/diagnosis of whatever was wrong with the child and "not" a well child visit?

Answer:

If you still performed the preventive then yes, you would have coded that as well as for the flu or cold. It really depends on documentation.

Question:

Do you have any recommendations on a good ICD-10 book set, the physician I work for is wanting me to let him know what I need, but I keep looking at all the choses and it's confusing!! Any advice on a real good one?

Thank you!

Answer:

We just came out with a new comprehensive manual. https://www.aapc.com/medical-coding-books/icd-10-cm-manual.aspx

Question:

Are there resources that can help me train providers in documentation concepts for particular specialty clinics?

Answer:

AAPC offers specialty specific online documentation training for providers. Here is the link to view the specialties we offer: https://www.aapc.com/ICD-10/ICD-10-physician-documentation.aspx . Our general and specialty specific boot camps also cover the main coding concepts for many codes. A comprehensive ICD-10 book was also just released and can be found at this link: https://www.aapc.com/medical-coding-books/icd-10-cm-manual.aspx.

Question:

How will Physician offices code CPOD and Anemia, and other codes that generally use "unspecified" codes?

Answer:

The general coding guidelines address unspecified codes by stating that if sufficient clinical documentation is unknown or is not available, the unspecified code is acceptable until a more specific diagnosis can be determined. COPD, for example has code choices for with exacerbation or with lower respiratory infection. If neither of these is supported, unspecified is used.

This is an opportunity for clinical documentation improvement.

Question:

On the AAPC website, I see ICD-10 training for 21 specialties, but Chiropractic is not one of them. Will this be available for the future or is there another option?

Answer:

Please check the website periodically as we add different things all the time. Some offices utilize the Orthopaedic specialty course as it contains musculoskeletal issues.

Question:

If a provider just indicates "morbid obesity" as the diagnosis, but does not include "due to excess calories" is E66.01 still the appropriate ICD-10 code to report for that?

Answer:

It would need to be documented, otherwise you would have to default to "unspecified".

Question:

What is the ICD-10 code for uncontrolled type I Diabetes with ketoacidosis?

Answer:

Look at category E10.1

Question:

What is the code equivalent to 38.93 a regular PICC line placed for medications such as antibiotics on an IP record without having the exact location documented on every chart?

Answer:

In ICD-10-PCS PICC lines placement is under Insertion of vascular access device. The body part that the line is placed is necessary to complete the code, but is in general terms (lower veins, upper veins, chest, abdomen, etc.).

Question:

How is the best way to train a Physician to start documenting for ICD-10?

Answer:

Run a practice management report with the most frequently used codes now, pull corresponding patient records and identify any missing documentation to make the transition to ICD-10-CM.

Question:

What is the dx code for partial dislocation of the elbow? (Is partial dislocation equal to subluxation)?

Answer:

A subluxation is a partial dislocation. If you look in the Alphabetic Index in ICD-10-CM under the main term Dislocation, with the subterm partial, it states, “see Subluxation, by site.” In order to code the elbow subluxation to the highest level of specificity, the site, type (anterior, posterior, Nursemaid’s elbow, etc.), laterality, and patient encounter would need to be documented. The codes are located under category S53, Dislocation and sprain of joints and ligaments of elbow. Without any further specific information, a subluxation of the elbow would be coded to S53.103, Unspecified subluxation of unspecified ulnohumeral joint.

Question:

What is the dx code for poorly controlled epilepsy? (is poorly controlled the same as intractable?)

Answer:

Yes - intractable means poorly controlled. G40.911 Epilepsy, unspecified with status epilepticus or G40.919 Epilepsy, unspecified, without status epilepticus. The type of epilepsy should be documented as well.

Question:

If the type of contrast (fluoro vs radiography) during a heart cath is not specified, is there a default position as we do not have an "unspecified" option.

Answer:

No, there are no defaults. The root type (fluoroscopy, radiography) and the contrast (high osmolar, low osmolar, other) would need to be specified in order to complete the ICD-10-PCS code.

Question:

Any idea how long we will still be dual coding after the 2015 implementation?

Answer:

It depends on many factors; outstanding ICD-9 claims as well as non HIPAA covered entities and whether or not they make the transition to ICD-10 as they are not mandated.

Question:

Is there a program or certification available for coding of MH/SUD?

Answer:

We have a specialty specific online training for behavioral health. It is located at this link with our other specialty specific ICD-10 trainings. https://www.aapc.com/ICD-10/online-icd-10-specialty.aspx.

Question:

Back to the initial "well child" visit/encounter; Scenario: Well child visit, so you would have a specific E&M code that corresponds but "if" during the encounter doc finds the child has a cough, or cold or something else wrong would that make the E&M change and would that also change the ICD-10 code to "abnormal findings," where you wouldn't code a "well child visit?"

Answer:

If the doctor performs a preventive service and then encounters an abnormal finding that requires significant additional work then you could bill for both a preventive and an E/M, depending on payer and documentation.

Question:

Did I understand correctly that "X" will be the place holder for codes that need to go out to the 7th character but don't require something in some of the interim spaces?

Answer:

IF I understand the question - an X is used for a place holder for a required 7th character. Not every code requires a 7th character with some categories that require only 3, 4, 5, or 6 characters to be a complete code.

Question:

Where or when can I take a hospice only seminar or boot camp, if there is any?

Answer:

There is none that I am aware of at this time.

Question:

When a chiropractor codes for example for Irritable bowel syndrome and then subluxations (pt. has not specific spinal complaints) would the IBS ICD code be listed first or the subluxation code?

Answer:

In the absence of sequencing guidelines then you would code first the driving nature of what the provider treated.

Question:

Any idea how long dual coding will still be practiced after the 2015 implementation?

Answer:

It depends on a couple of situations. One is outstanding I9 claims, the other being how many non HIPAA covered entities you participate with as they are not mandated to make the change to ICD-10.

Question:

To follow up on the question about physical exams with or without abnormal findings...it is only considered an abnormal finding if it is something found on exam?? So if the patient comes in with a concern at their physical, but it is not enough to split bill a separate E/M would it be physical exam with or without abnormal finding? Example...a patient is in for a physical, but also brings up some shoulder pain...the provider says he thinks it is a tendonitis and advises to watch and recommends no treatment. Would that be a physical with or without abnormal findings?

Answer:

Without seeing medical records it is hard to give you a firm "it is always this way" answer. It depends on the work the physician has to do and the patient’s clinical condition.

Question:

Do you have to be a member of AAPC for assistance?

Answer:

Thank you for your inquiry. All participants are free to ask questions of the AAPC trainers during today's CMS-AAPC ICD-10 Code-a-thon.

Question:

Will the DSM-V be incorporated into ICD-10?

Answer:

DSM-V has "crosswalks" to ICD-10 built in it.

Question:

When to use unspecified codes? Working in a family practice/urgent care facility, we use several unspecified codes because information is unavailable at the time of visit. Should we continue to use the codes in ICD-10?

Answer:

The general coding guidelines and chapter specific guidelines for Chapter 18 state that the use of unspecified codes is acceptable to report unspecified codes when sufficient clinical information is not known or is not available. Unspecified codes should be reported if they most accurately reflect what is known about the patient's condition. When more specific information is known it should be documented and a more specific code assigned in the future.

Question:

What is the ramification if most providers in the country default to "unspecified."

Answer:

We have heard from many plans that have said the use of unspecified codes will not guarantee payment, the continued use of unspecified codes will reduce payments and the use of unspecified codes will pend your claim until education is provided. Under each of these scenarios revenue is impacted.

Question:

When will Coding Clinics be updated to reflect ICD-10?

Answer:

Coding clinic will not be updated. The Cooperating Parties have determined that it would not be very useful to convert old Coding Clinics to ICD-10. Instead, we launched providing ICD-10 advice in the 4th Quarter 2012 issue of Coding Clinic for ICD-9-CM. http://www.ahacentraloffice.org/codes/products.shtml#CCICD10

Question:

Besides physician queries what other avenues are useful for discovering documentation issues?

Answer:

We have found documentation assessments of the actual medical records to be most helpful. You can run a report by diagnosis code and look at specific issues, or make it random. Code the records pulled in ICD-10-CM and look for unspecified code usage and what was missing from the documentation that kept a more specific code from being used. Then the physician can be sat down with and educated specifically on his/her own documentation issues. This is a service that AAPC provides, or may be performed by your own in-house ICD-10 educators.

Question:

1. An OB patient delivers in the first week of October, 2015 and her insurance requires a split bill of prenatal and delivery. Would the prenatal care which occurred prior to 10/1/15 be billed with ICD-9 and the delivery with ICD-10? And if so, are those on two separate claim forms as well? Or does prenatal care get the ICD-10 code assigned since the delivery occurred after the implementation date?

Answer:

The general rule is that any service before Oct 1, 2015 will be billed with ICd-9 codes and after October 1, 2015 ICd-10 is used. However, this could be specific to the payer and being pro-active with the payer could be to your advantage.

Question:

When coding sprains of either upper or lower limbs you do not have an unspecified option as we do in I-9. If no further documentation is available in the record, can you use non-physician documentation (such as radiology report) for further clarification?

Answer:

From a compliance perspective, you would need to follow your facilities policies and procedures. If this is a condition that you will be coding often in ICD-10-CM, it would benefit everyone in a better manner to educate the providers on the documentation concepts that are necessary for sprains. That way, no further reviewing of the medical record to try and find other documents would be necessary. The key documentation concepts for sprains are: site (specific to ligament or joint), laterality, if any open wound is present, and patient encounter.

Question:

Do stablished patients will need to sign new documentation for our practice or only new patients?

Answer:

I am not quite sure what you are referencing.

Question:

Are there coding books or resources that you can recommend that detail specifically when coders need to query the provider.

Answer:

No, not that I am aware of.

Question:

Will providers still need to use the RT/LT/50 modifiers with the diagnosis codes that already specify the laterality?

Answer:

This will be payer specific. At this time those modifiers will not be going away.

Question:

Are there resources that are available that can help me get information regarding coding for the hospice environment, particularly -assistance with guidelines that are hospice specific?

Answer:

Not that I am aware of at this time.

Question:

Patient has chronic systolic CHF and Diastolic dysfunction. Are two codes needed?

Answer:

There are combination codes in ICD-10-CM for heart failure. The codes are located under category I50 and are broken down by type (systolic, diastolic, combined systolic and diastolic) and temporal parameter (acute, chronic, acute on chronic). If a patient has chronic systolic and diastolic CHF, the correct code in ICD-10-CM is the combined code I50.42, Chronic combined systolic and diastolic heart failure.

Question:

In our practice now, we are able to use an encounter form where the physician can mark his most frequently used diagnoses and then hand it to us to file the claim. Am I right is telling him that this is no longer an option? We will have to code from the medical record.

Answer:

It is a business decision that needs to be vetted out, the answer can be different for differing practices. My suggestion is to provide the physician with a tool that shows the conditions you see most often if you continue to put codes on the encounter form.

Question:

Do you recommend OP CDI programs to address unspecified code use?

Answer:

Yes, absolutely

Question:

I just wanted to put my 2 cents worth in....you all are doing a fantastic job of fielding these questions....I sure hope they will all be in the transcript.....thanks again for this learning opportunity.

Answer:

Thank you so much!

Question:

With the OIG coming down on SNF/NF's for their E/M documentation, why is it that the AAPC does not offer any classes on E/M for SNF/NF MD/NP's?

Answer:

Good question, we will see what we can do.

Question:

Are the commercial insurance companies also mandated to use ICD 10 codes from Oct 1, 2015?

Answer:

The ICD-10 conversion is a HIPAA mandate. All covered entities must convert to the new system on the same date. HIPAA defines covered entities as HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

Question:

Established Pt have sarcoidosis, diabetes, seizures with a new complaint of "knots on spine". How would the new complaint be categorized if it is related to the sarcoidosis?

Answer:

Without seeing the medical record it would be difficult to speculate on the correct coding of this.

Question:

Will coders have to query the provider every time congestive heart failure is documented?

Answer:

No, instead provide clinicians with good documentation tools.

Question:

Let me try to ask this again. We have to track all comorbid conditions for our dialysis patients. One method of doing this is through the hospital discharge sheet if they have been hospitalized. How can we be sure we are coding correctly when the diagnosis comes from a specialty other than nephrology?

Answer:

The only way you can do that is to change your business process, otherwise you will have to rely on the coding of others.

Question:

Will insurance companies be accepting the new ICD-10 codes before October 1, 2015?

Answer:

I do not know of any that will do this other than in testing.

Question:

You didn't mention anything about PCS. Please explain why they just didn't go with CPT instead of creating PCS? Why do we need two procedure sets?

Answer:

ICD-10-PCS was made to replace volume III of ICD-9-CM, which is the procedure code set used now by facilities.

Question:

EHR software automatic converted provider documentation into icd10 code can we change it as a coder if wrong or missing numbers in claims?

Answer:

I would not take the risk of allowing a vendor to convert codes for you without clinical input from your practice.

Question:

Is there any neoplasm coding webinar

Soon from AAPC.....most webinar hardly talk cancer coding or procedure

Answer:

I will make sure this is noted; hopefully you will see it soon.

Question:

If for some reason...you cannot determine specificity because of lack of history...what should be coded?

Answer:

Codes can only be assigned based on clinical documentation. It may be necessary to query the provider.

Question:

My question is , there is certain drugs that Medicare require certain DXs codes to go with the drug is this going to change , like not more than 2 DXs codes.

Answer:

Medical policies will change to reflect the new codes.

Question:

Can you recommend a good resource for documentation tools for Behavioral Health Providers?

Answer:

AAPC has a quick reference flip book that goes along with the provider education. https://www.aapc.com/ICD-10/physician-icd-10-training.aspx

Question:

Is worker comp going to use ICD-10? The last I heard it was still up in the air.

Answer:

This is state by state, carrier by carrier. You should check with each plan you participate with.

Question:

Who in the HIMs Department should be instrumental in training providers ICD-10 coding documentation essentials and doing documentation audits? Should the coding supervisor and auditor participate? We currently do not have a documentation specialist to do this essential work.

Answer:

In the absence of a CDI specialist the supervisor and auditor would be a good choice.

Question:

We use 278.01 for all of our patients because we are a bariatric surgeon’s office. Will this code change for ICD 10

Answer:

The structure will change for all ICD-10 codes. Obesity and Overweight are found in category E66, and based on the severity or cause of the obesity. An instructional note states to code also the BMI, if known.

Question:

I know of a small solo physician practice that does not find it feasible in their current revenue status to purchase an ICD10 compatible billing system. What sorts of penalties are involved and can they continue to submit with ICD9 codes?

Answer:

They will not be able to submit with ICD-9 for most vendors. My suggestion would be to use a billing service if they feel they cannot upgrade. Without a change they wont be able to get paid.

Question:

How is the code set for Interventional Radiology going to be in IC D-10?

Answer:

The mapping is fairly concise from one code set to the other.

Question:

Earlier someone asked about the best place to get the new books. I followed the link, and found what I want to order, but how do I put in my member information in order to get the discount?

Answer:

Log in first and then click the link

Question:

I get asked all the time why we don't just skip to I11---how realistic is that as an option?

Answer:

It is not an option. ICD-11 is not out in beta yet. When they do put it out, it will be decades beyond before we have a clinically modified (CM) version.

Question:

Just wanted to say you're doing an excellent job fielding and answering the questions. Thank-you!

Answer:

Thank you!

Question:

ICD-10-PCS is the procedure coed set....will it replace CPT code in October 1, 2015?

Answer:

No, it replaces Volume 3 of ICD-9-CM for facility procedures. CPT is still for use for physician out patient coding.

Question:

If the only documentation you have is acute abdominal pain of unknown cause would you code only the abdominal pain or would you add R52, in addition.

Answer:

Just the code for the abdominal pain.

Question:

I have noticed the AAPC does have quick reference guides for most specialties but Oncology and/or Pathology. Is there a plan to some for them as well?

Answer:

If you are referring to our Fast Forwards, we actually do have one for Oncology/Hematology, and one for Pathology. They can be found at this link: https://www.aapc.com/ICD-10/crosswalks/index.aspx.

Question:

Will there be any coding specific materials for Hospice presented in the future?

Answer:

Not that I am aware of. We have been receiving requests for this, so please watch our website.

Question:

Is there still a code for multiple rehab proc nec V57.89?

Answer:

V57.89, Multiple training or therapy maps to Z51.89 encounter for other specified aftercare, which is a default code (non-descript). There is an extensive list of aftercare codes in the alphabetic index that might better describe the encounter. The alphabetic index also refers the user to the term "care".

Question:

What is the correct ICD-10 code(s) for Neurogenic claudication lumbar 724.03? Converted ICD-10 data on line takes us to just spinal stenosis lumbar M48.06. Should we use R29.818 along with the spinal stenosis lumbar code?

Answer:

Without seeing the medical documentation it would be hard to provide guidance on this.

Question:

Follow up on the question a few above. We are a Physical Therapy practice. So we will most likely never be the first person a patient sees to be treated for an injury. So am I correct in understanding we would code the seventh character as "D"? You answer mentioned a new encounter by a new physician so am now wondering if we would in fact put an "A" for the evaluation DOS Please clarify. Thank you

Answer:

The use of the 7th characters A or D is not based on whether you are the first person to see the patient, but on the treatment itself. 7th character A, initial encounter, is assigned when the patient is receiving active treatment for the condition. 7th character D, subsequent encounter, is assigned when the patient has completed active treatment and is in the healing or recovery phase. Don't get hung up on the word initial in the descriptor. If you look in the guidelines (I.C.19.a) it lists examples of initial and subsequent encounters.

Question:

This may be addressed later, but I would like to know about the CMS guidelines on diagnosis pointers. The instructions say to list only ONE pointer per line; but are all diagnosis codes listed in box 21 if they are not used as pointers?

Answer:

I believe this depends on how your billing system is set up.

Question:

How would you code electronic cigarettes without any clarification of whether nicotine is present in the e-liquid being used?

Answer:

We don’t believe there is a code at this time, unless it contains nicotine. I would query the provider to document the use of nicotine when it is used.

Question:

Is this webinar pertinent to us that do ground ambulance billing?

Answer:

Only certain concepts

Question:

What specific resources have been developed for training with skilled nursing facilities?

Answer:

There are none that I am aware of currently.

Question:

Can we download this code-a-thon and is there a specialty list my doctor is a Optometric Physician for our ICD 10 codes

Answer:

AAPC offers training for physicians on this specialty. I am not sure if this webinar downloadable but I do know a link will be provided to watch.

Question:

I just want to say thank you,

An eye opener for icd10 coding. Learned a lot!

Answer:

Thank you!

Question:

So we don't officially have to start reporting with ICD-10 codes until October 2015 or will some insurances start excepting ICD-10 coding before then?

Answer:

ICD-10 will not be reported for reimbursement until October 1, 2015

Question:

What is the difference between removal and excision?

Answer:

If you are asking in terms of ICD-10-PCS, a Removal is taking out or off a device from a body part, and an Excision is cutting out or off without replacement, a portion of a body part (the body part itself, not a device).

Question:

For more follow-up, is applying an Ace wrap the initiation of active treatment by the ED physician, so that all follow-up by any healthcare provider is a subsequent encounter until the patient is healed or recovered? You say don't get hung up by "initial", but CDC/CMS created "initial" and "subsequent" encounters for ICD-10 knowing CPT uses the same terms only initial means initial encounter in CPT and subsequent means subsequent encounter...which is not the same in ICD-10.

Answer:

I cannot give you a definitive answer without knowing more; it really depends, and will be dependent on provider’s clinical determination.

Question:

Thank you, this was very informative.

Answer:

Thank you!

Question:

During the audio slide show there was mention of "Documentation Concepts" that should be used to train providers. Do you have any more specific resources that could be utilized to explain these specialty concepts to providers?

Answer:

Yes, AAPC provides specific training by specialty for physicians and for coders we have a CDI for ICD-10-CM course that will launch this week. https://www.aapc.com/ICD-10/physician-icd-10-training.aspx

Question:

Is it true the reimbursement from the INS Company will change when we start reporting ICD10? Can u pls clarify?

Answer:

It depends and varies by carrier. You should check to see what changes are being made with each health plan you currently contract with.

Question:

If a physician works in a rehab hospital, will all of his 7th character codes be the letter D even on the admission date?

Answer:

It would be hard for me to confirm a broad statement such as this without seeing medical records.

Question:

Physicians sometimes use the terms "renal insufficiency", "renal failure", and “Acute kidney injury” interchangeably, but the ICD-9-CM classifies these terms to different codes. ICD-9-CM classifies unspecified and acute renal insufficiency to code 593.9, whereas acute kidney failure is assigned to category 584. Are there any criteria how these terms should be coded in ICD-10?

Answer:

In ICD-10-CM, when the main term Injury, with the subterms kidney, acute are referenced, it sends the user to N17.9, Acute kidney failure, unspecified. When the main term Failure, with the subterm renal is referenced, it sends the user to N19, Unspecified kidney failure. When the main term Insufficiency, with the subterm renal, it sends the user to N28.9, Disorder of kidney and ureter, unspecified. This is a good example of a case where a provider needs to state what they mean in their documentation in order to have the appropriate diagnosis code assigned. I would show the provider(s) how each of the terms codes out in ICD-10-CM to make them aware of how their statements for these conditions will change the code selection in ICD-10-CM.

Question:

Related to the encounter codes A and D: What is the definition of "active" treatment associated with the "A" character? When does "active" change to "subsequent"?

Answer:

Right now the guidelines are vague, we are looking for further clarification and hope to see it in future printings.

Question:

When will the final ICD-10-CM and -PCS coding books be available?

Answer:

The code books that are currently published in the United States are considered "Draft" just because we are not using them live. Once we "go live" on ICD-10, the code books will be "Final".

Question:

Q: In osteomyelitis, the descriptor of acute or chronic is required in order to assign a specific code with laterality and/or other descriptors. If you know the type/origin of the osteomyelitis and the location (left femur) but acute or chronic is not documented, the default code in the index indicates M86.9 to be assigned without further specificity. This makes no sense. Why wouldn’t ICD 10 allow the assignment of a default for acute vs chronic rather than to assign a NOS code? ICD 10 has listed other defaults => dominant vs non-dominant side, or a fracture not indicated as open or closed should be coded to closed. Is this an oversight?

Answer:

If you believe that this is an error you should report it to the CDC and try to get it fixed.

Question:

Patient had hip replacement. Is sent to a SNF for rehab for aftercare of hip replacement. Since we have no aftercare codes how would this be coded.

Answer:

The Alphabetic index has an extensive listing of aftercare codes. The index also refers the user to see "care". Category Z47 contains codes for Orthopedic aftercare.

Question:

Is there a need to order ICD-9 books for 2015? If I am correct, there is still a freeze on those codes and no changes have been mande. Is this correct?

Answer:

This is correct.

Question:

I've written my Senators and Representatives about not delaying ICD-10 again or coupling it with SGR legislation. I realize this is a code-a-thon but any recommendations that might make a difference beyond the actions I've already taken?

Answer:

Show them your success stories.

Question:

Hi, my name is Nataliya Fabrje, I am a CPC.

I would like to know if I have passed the Proficiency Exam in ICD-10 through AAPC, would I need any other training in it?

Answer:

No, you would not, unless you wanted it.

Question:

Do you know why CMS is not allowing a grace period where both ICD9 and ICD10 codes will be accepted?

Answer:

While this sounds simple in theory there is no way to logistically pull this off. Vendor systems would have to be completely rewritten (if they even could) and it would not be easy (if not impossible) to determine who is submitting under what codes and what system to process it under.

Question:

How would you could a left submandibular neoplasm-rule out pleomorphic adenoma versus malignancy. Imaging has failed to show any evidence of metastatic nodes.

Answer:

Without seeing medical documentation this would be difficult to determine.

Question:

Is AAPC will use icd10 coding for coder cert test on Oct 2015?

Answer:

January 2016 will include ICD-10 codes.

Question:

I am not sure the question from the chiropractor's office was answered very clearly. Forgive me if I am wrong, but I understood that the 7th character A would be used when a new physician sees the patient (as the result of a referral from the ED, for instance), but that then that physician would use D for subsequent visits to treat the problem. Isn't that correct?

Answer:

If the patient is considered to be receiving active treatment for the condition, the correct 7th character extender is A. If the patient is considered to be in the healing or recovery phase of the condition, the correct 7th character extender is D. The documentation should indicate the phase of treatment.

ANNETTE HOWELL:

How will this affect ambulance billing since we don't dx but based and signs and symptoms? Do you know if Medicare may come out with a Conditional Code list like they have for us now? Also how can we get credit for this webinar to us as CCU?

Answer:

ICD-10-CM has sign and symptom codes the same as ICD-9-CM. You will continue to code in the same way. I do not know if Medicare may come out with a Conditional Code list like they have now. Please inquire with Medicare.

Question:

CERTIFICATION TESTING: Some are prepared to take the certification exams for ICD 10 now. When will the following exams for ICD 10 will be available to take? Please elaborate on specific dates, if known. If unknown, what are your predictions for certification testing dates? Furthermore, will they implement the use of 3M or another encoder to be used during testing? (This would be beneficial to all).

CPC ; CPC-H ; CIC ;CPC-P; CCS (ICD 10 ONLY)

Answer:

AAPC certification exams will contain ICD-10 codes beginning January 2016.

Question:

What are non HIPPA covered entities?

Answer:

Those not covered under HIPAA regulations, such as workers comp, auto....

Question:

Can you explain the Includes and excludes notes included within the categories?

Answer:

The Includes notes provide supplemental information to further define or give examples of the code category.

There are 2 kinds of Excludes notes. ExcludesI and ExcludesII.

Excludes1 is means that the codes excluded should never be used with t he code that is above the Excludes1 note.

Excludes2 notes indicate that the condition excluded is not part of the condition above the exclusion, and if both conditions are documented, both can be separately reported.

This explanation can be found in the coding convention in Section1.A.10 and Section1.A.12.a-b.

Question:

Do the AAPC "fast forward" mappings include a specialty for hospice?

Answer:

Not specifically, but there is a multi-specialty one that might fit.

Question:

I looked on the AAPC website and it says we can pre order the ICD 10 CM, but it won't be delivered until next September. Is there something I can do to study the accepted codes before then?

Answer:

It is available in just a couple of weeks. You can also download the files from the CDC website.

Question:

The CDC site: http://www.cdc.gov/nchs/icd/icd10cm.htm

does not yet have 2015 version of Official Guidelines for Coding and Reporting - they just have 2014 version; this is the same as CMS site. Has the deadline passed for 2015 version and will we just use the 2014 version?

Answer:

From the CDC website: http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2015

Although the FY 2015 ICD-10-CM is now available for public download and viewing, the codes in ICD-10-CM are not currently valid for any purpose or use. Please see above regarding the pending interim final rule which will give the effective implementation date for ICD-10-CM (and ICD-10-PCS), currently anticipated to be October 1, 2015. Updates to ICD-10-CM are anticipated prior to its implementation.

Any questions regarding typographical or other errors noted on this release may be reported to Donna Pickett, e-mail dfp4@cdc.gov.

Question:

Will CMS be offering any trainings specific to hospice and ICD-10 coding?

Answer:

Not that I am aware of

Question:

Will AAPC make a public statement in support of ICD-10? We need support to make it happen in 2015.

Answer:

AAPC continues to show the success stories with implementation and to drive the industry forward. We continue to work with leaders in the industry such as WEDI and CMS as well.

Question:

We are Anesthesia providers and have at times had issues with the way the patients doctor codes things. Are we going to have modifiers or something special to follow to go with patient’s doctors coding? Of just simply doing the CPT, NDC, etc... will do?

Answer:

Modifiers will not be changing with the implementation of ICD-10.

Question:

Are there a lot of changes coding V-codes?

e.g. V66.2, V45.11, V58.61

Answer:

Not tremendous.

Question:

Is there a code for "non-healing" pressure ulcer?

Answer:

A non-healing pressure ulcer should be coded to the current stage of the pressure ulcer. If no stage is given, then an unspecified stage code would need to be assigned.

Question:

I have an ICD-10-CM 2014 Draft. Do I need to order a 2015 Draft book?

Answer:

The information has not changed as we are in a code set freeze.

Question:

My understanding is that pregnancy diagnosis is to be primary no matter what the pregnant person is being seen for. Is this correct? I.e. pregnant lady goes to ED for fall and breaks her foot. Do code her pregnancy state then fx foot

Answer:

Chapter 15 codes always take sequencing priority according to guidelines

Question:

How about if payer is not ready for icd10?

Answer:

This should not happen, we have seen clear indications that most will be ready or are already ready. But you should check with each plan you participate with to see their status.

Question:

Do you need to be a member of AAPC to take coding classes?

Answer:

No you do not.

Question:

Fracture coding? If the pt is referred to a practice by another MD - Would this still be an initial fracture care? Or subsequent care?

Answer:

As long as the physician is providing active care.

Question:

If provider doesn't use the E-code describing injury will this affect the reimbursement? In other words, if the code only describes the injury not "how" it happened. Will this bill be rejected?

Answer:

According to the Official Draft Guidelines (I.C.20) there is no national mandate on the use of External cause codes. It will be up to individual payers regarding requirement of these codes for reimbursement.

Question:

Per the ICD 10 index for Diabetes, "with", now lists many complications of diabetes; nephropathy, neuropathy, gastropareisis... where ICD 9 index only showed a few; hyperosmolarity, osteomyelitis... Is it to be understood that the physician does not have to link the conditions listed under "with" for ICD 10 to code as a diabetic condition?

Answer:

No, the guidelines will state when you can assume cause and effect, otherwise you should look to the provider’s documentation.

Question:

How would you code "leg (limb) swelling" in ICD-10? Currently reported with 729.81 in ICD-9.

Answer:

With category R22, it is broken down by anatomical location and laterality.

Question:

How do we diagnose a routine outpatient prenatal visit when a patient does have a complication being managed as well, but is not considered high-risk? Example gestational diabetes. Do we use the Z34 supervision code with the gestational diabetes or just the gestational diabetes on those visit? The Coding guidelines say not to use these codes (Z34) in conjunction with chapter 15 codes....but the intent of the visit is the supervision/routine prenatal but they are indicating the gestational diabetes is well controlled, etc.

Answer:

In this scenario the code for gestational diabetes would be used. You are correct that Z34, supervision of normal pregnancy is not used with Chapter 15 codes based on the ExcludesI note for Z34 stating that any complication of pregnancy (O00-O9a) is listed as primary.

Question:

Are the osteopathic manipulation codes in ICD10-PCS only for use inpatient?

Answer:

ICD-10-PCS is a replacement code set for Volume III of ICD-9-CM. Wherever CPT is currently used today, it will continue to be used under ICD-10.

Question:

Are you aware of any ICD10 training programs especially regarding radiology?

Answer:

Not for coders that I am aware of, but we do have it for physicians.

Question:

No question....just want to thank y'all for taking the time to answer all of our questions. I have a better understanding as to what is needed to be done to prepare our cite for ICD-10. Thanks so much!!!

Answer:

Thank you!