Coding and Reimbursement Update – September 2011
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ICD-9 Changes Effective October 1, 2011

ICD-9 is updated with the government's fiscal year which is confusing for some practices as they forget that this means the 2012 *ICD-9* codes become effective October 1, 2011. As in past years, practices need to update superbills, cheat sheets, practice management systems, etc. to reflect *ICD-9* changes. Physicians using electronic medical records should contact their vendors for information about updating the *ICD-9* diagnosis code database. Any personal quick pick or favorite list of diagnosis codes also need to be updated.

The 2012 changes pertinent to ophthalmology include, but are not limited to:

New Diagnosis Codes

Diagnosis Code	Description
173.10	Unspecified malignant neoplasm of eyelid, including canthus
173.11	Basal cell carcinoma of eyelid, including canthus
173.12	Squamous cell carcinoma of eyelid, including canthus
173.19	Other specified malignant neoplasm of eyelid, including canthus
365.05	Open angle with borderline findings, high risk
365.06	Primary angle closure without glaucoma damage
365.70	Glaucoma stage, unspecified
365.71	Mild stage glaucoma
365.72	Moderate stage glaucoma
365.73	Severe stage glaucoma
365.74	Indeterminate stage glaucoma
379.27	Vitreomacular adhesion
V12.21	Personal history of gestational diabetes
V19.11	Family history of glaucoma
V19.19	Family history of other specified eye disorder

Invalid Diagnosis Codes October 1, 2011

Diagnosis Code	Description
173.1	Other malignant neoplasm of skin of eyelid, including canthus

Revised Diagnosis Code Titles Effective October 1, 2011

Diagnosis Code	Description
365.01	Open angle with borderline findings, low risk

Continued next page

Glaucoma New Codes

The American Academy of Ophthalmology requested new codes be created so physicians can capture the stage of disease when coding for the most commonly encountered types of glaucoma. Glaucoma is characterized by optic nerve damage that results in visual field loss as the disease progresses to more advanced stages. The most common types of glaucoma are

- Primary open angle glaucoma (POAG)
- Primary angle closure glaucoma
- Pigmentary glaucoma
- Corticosteroid-induced glaucoma
- Pseudoexfoliation glaucoma, and
- Glaucoma associated with ocular inflammation, ocular vascular disorders, and ocular trauma.

Patients present at vastly different stages of disease, and typically treatment at early stages of disease results in better outcomes and uses fewer resources than patients who present with more severe stages of glaucoma.

Beginning with dates of service on or after October 1, 2011, physicians will report two codes for the majority of glaucoma patients. The primary diagnosis is the patient's type of glaucoma. The second code is the current stage of glaucoma. Coding to the greatest extent known at the time of the encounter may assist the payer with identifying the need for more frequent visits and tests.

Again, trying to capture additional information related to the modern glaucoma evaluation that now entails the assessment of clinical factors in determining risk for the development of open angle glaucoma, the AAO requested codes to stratify patients with borderline findings into low-risk and high-risk. Similarly, the AAO also requested angle closure code revisions to be consistent with current worldwide terminology.

Effective October 1, 2011, the glaucoma section in *ICD-9* includes the following codes:

365.0 Borderline glaucoma [glaucoma suspect]
365.00 Preglaucoma unspecified
365.01 Open angle with borderline findings, low risk
365.02 Anatomical narrow angle
365.03 Steroid responders
365.04 Ocular hypertension
365.05 Open angle with borderline findings, high risk
365.06 Primary angle closure without glaucoma damage

365.1 Open-angle glaucoma
365.10 Open-angle glaucoma, unspecified
Wide-angle glaucoma NOS
Use additional code to identify glaucoma stage (365.71-365.74)
365.11 Primary open angle glaucoma
Chronic simple glaucoma
Use additional code to identify glaucoma stage (365.71-365.74)
365.12 Low-tension glaucoma
Normal tension glaucoma
Use additional code to identify glaucoma stage (365.71-365.74)
365.13 Pigmentary glaucoma
Use additional code to identify glaucoma stage (365.71-365.74)
365.14 Glaucoma of childhood
Infantile or juvenile glaucoma
365.15 Residual stage of open angle glaucoma

365.2 Primary angle-closure glaucoma
365.20 Primary angle-closure glaucoma, unspecified
Use additional code to identify glaucoma stage (365.71-365.74)
365.22 Acute angle-closure glaucoma
Acute angle-closure glaucoma crisis
Acute angle-closure glaucoma attack
365.23 Chronic angle-closure glaucoma
Primary angle closure glaucoma
Use additional code to identify glaucoma stage (365.71-365.74)
365.24 Residual stage of angle-closure glaucoma

365.3 Corticosteroid-induced glaucoma
365.31 Glaucomatous stage
Use additional code to identify glaucoma stage (365.71-365.74)
365.32 Residual stage

365.4 Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
365.41 Glaucoma associated with chamber angle anomalies
365.42 Glaucoma associated with anomalies of iris
365.43 Glaucoma associated with other anterior segment anomalies
365.44 Glaucoma associated with systemic syndromes
Code First: associated disease, as:
neurofibromatosis (237.70-237.79)
Sturge-Weber (-Dimitri) syndrome (759.6)

365.5 Glaucoma associated with disorders of the lens
365.51 Phacolytic glaucoma
365.52 Pseudoexfoliation glaucoma
Use additional code to identify glaucoma stage (365.71-365.74)
365.59 Glaucoma associated with other lens disorders

365.6 Glaucoma associated with other ocular disorders
Use additional code to identify glaucoma stage (365.71-365.74)
365.60 Glaucoma associated with unspecified ocular disorder
365.61 Glaucoma associated with pupillary block
365.62 Glaucoma associated with ocular inflammations
Use additional code to identify glaucoma stage (365.71-365.74)
365.63 Glaucoma associated with vascular disorders
Use additional code to identify glaucoma stage (365.71-365.74)
365.64 Glaucoma associated with tumors or cysts
365.65 Glaucoma associated with ocular trauma
Use additional code to identify glaucoma stage (365.71-365.74)

New subcategory 365.7 Glaucoma stage
Code first associated type of glaucoma (365.11-365.13, 365.26, 365.31, 365.52, 365.62-365.63, 365.65)
365.70 Glaucoma stage, unspecified
365.71 Mild stage glaucoma
Early stage glaucoma
365.72 Moderate stage glaucoma
365.73 Severe stage glaucoma
Advanced stage glaucoma
End-stage glaucoma
365.74 Indeterminate stage glaucoma
Glaucoma stage NOS

As previously mentioned, beginning October 1, 2011, in addition to clearly identifying the type of glaucoma, the physician needs to document in the patient's progress note and assign the correct code that describes the problem. Continuing with the diagnosis of glaucoma, the physician's diagnostic statement related to primary open angle glaucoma needs to be sufficient to support one of the following coding options:

- Primary open angle glaucoma, stage, unspecified (365.11 + 365.70)
- Primary open angle glaucoma, mild stage (365.11 + 365.71)
- Primary open angle glaucoma, moderate stage (365.11 + 365.72)
- Primary open angle glaucoma, severe stage (365.11 + 365.73)

ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2011 Glaucoma

1. For types of glaucoma classified to subcategories 365.1-365.6, an additional code should be assigned from subcategory 365.7, Glaucoma stage, to identify the glaucoma stage. Codes from 365.7, Glaucoma stage, may not be assigned as a principal or first-listed diagnosis.
2. Bilateral glaucoma with same stage
   When a patient has bilateral glaucoma and both are documented as being the same type and stage, report only the code for the type of glaucoma and one code for the stage.
3. Bilateral glaucoma stage with different stages
   When a patient has bilateral glaucoma and each eye is documented as having a different stage, assign one code for the type of glaucoma and one code for the highest glaucoma stage.
4. Bilateral glaucoma with different types and different stages
   When a patient has bilateral glaucoma and each eye is documented as having a different type and a different stage, assign one code for each type of glaucoma and one code for the highest glaucoma stage.
5. Patient admitted with glaucoma and stage evolves during the admission
   If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.
6. Indeterminate stage glaucoma
   Assignment of code 365.74, Indeterminate stage glaucoma, should be based on the clinical documentation. Code 365.74 is used for glaucomas whose stage cannot be clinically determined. This code should not be confused with code 365.70, Glaucoma stage, unspecified. Code 365.70 should be assigned when there is no documentation regarding the stage of the glaucoma.

Family History of Glaucoma – New Codes

ICD-9 2012 also provides a means to code the family history of glaucoma

Code V19 Family history of other disorders has been expanded to

- V19.10 Blindness or visual loss
- V19.11 Glaucoma
- V19.19 Other specified eye disorder

Vitreomacular Adhesion – New Code

Vitreomacular adhesion (VMA) is not a new condition; however, the American Academy of Ophthalmology and the American Society of Retina Specialists felt there is a need from a broad health care perspective to be able to track this discrete and potentially sight-threatening condition, understand its true prevalence, and identify it separately from other traction disorders as well as associated or downstream conditions.

Both researchers and clinicians have recognized VMA as a separately identifiable condition that contributes to serious vision threatening conditions, and warrants its own distinct and unique treatment upon anatomical or visual signs and symptoms of vitreomacular traction. As advanced diagnostic

techniques have become universally available in the last decade and new treatments enter the health care marketplace, these ophthalmic societies believe clinicians and researchers alike would benefit greatly from separately identifiable VMA coding.

379.2 Disorders of vitreous body
379.21 Vitreous degeneration
Vitreous:
cavitation
detachment
liquefaction
379.22 Crystalline deposits in vitreous
Asteroid hyalitis
Synchysis scintillans
379.23 Vitreous hemorrhage
379.24 Other vitreous opacities
Vitreous floaters
379.25 Vitreous membranes and strands
379.26 Vitreous prolapse
379.27 Vitreomacular adhesion
Vitreomacular traction
Excludes: traction detachment with vitreoretinal organization (361.81)
379.29 Other disorders of vitreous
Excludes: vitreous abscess (360.04)

***ICD-9* Coding – Have You Been Coding to the Greatest Extent Known?**

In the early 1980s, Medicare began requiring physicians to use *ICD-9* and *CPT* codes on claims. Commercial payers quickly followed Medicare's lead. Since failure to use valid *ICD-9* codes resulted in denied claims, physicians quickly learned they were required to report the diagnosis code to the highest level of specificity. This continues to mean physicians must follow these guidelines

- Assign a three-digit codes (known as category codes) only if there are no four-digit codes within the code category.
- Assign a four-digit code (known as subcategory codes) only if there are no five-digit codes for that category.
- Assign a five-digit code (knows as fifth-digit subclassification codes) for that category.

In an attempt to have as many pertinent diagnosis codes as possible on superbills, many practices selected "unspecified" codes to describe services. Some practices have not always coded to "the greatest extent known." Using clinical judgement and results of any diagnostic tests, physicians should be documenting a complete diagnostic statement and assigning the most specific code available to describe the patient's problem. For example, even to this day, some practices continue to report 372.30 conjunctivitis, unspecified whenever a patient has conjunctivitis. Actually, all of the following codes are available to report conjunctivitis and this list is not all-inclusive:

077.0 Inclusion conjunctivitis
Paratrachoma
Swimming pool conjunctivitis
Excludes: inclusion blennorrhea (neonatal) (771.6)
077.1 Epidemic keratoconjunctivitis
Shipyard eye
077.2 Pharyngoconjunctival fever
Viral pharyngoconjunctivitis
077.3 Other adenoviral conjunctivitis
Acute adenoviral follicular conjunctivitis

077.4 Epidemic hemorrhagic conjunctivitis
Apollo:
conjunctivitis
disease
Conjunctivitis due to enterovirus type 70
Hemorrhagic conjunctivitis (acute) (epidemic)
077.8 Other viral conjunctivitis
Newcastle conjunctivitis
077.9 Unspecified diseases of conjunctiva due to viruses and Chlamydiae
077.98 Due to Chlamydiae
077.99 Due to viruses
Viral conjunctivitis NOS
098.40 Gonococcal conjunctivitis (neonatorum)
130.1 Conjunctivitis due to toxoplasmosis
370.31 Phlyctenular keratoconjunctivitis
Phlyctenulosis
Use Additional Code: for any associated tuberculosis (017.3)
370.32 Limbar and corneal involvement in vernal conjunctivitis
Use Additional Code: for vernal conjunctivitis (372.13)
370.33 Keratoconjunctivitis sicca, not specified as Sjögren's
Excludes: Sjögren's syndrome (710.2)
370.34 Exposure keratoconjunctivitis
370.35 Neurotrophic keratoconjunctivitis
370.40 Keratoconjunctivitis, unspecified
Superficial keratitis with conjunctivitis NOS
370.44 Keratitis or keratoconjunctivitis in exanthema
Excludes: herpes simplex (054.43)
herpes zoster (053.21)
measles (055.71)
Code First: underlying condition (050.0-052.9)
370.49 Other
Excludes: epidemic keratoconjunctivitis (077.1)
372.00 Acute conjunctivitis, unspecified
372.01 Serous conjunctivitis, except viral
Excludes: viral conjunctivitis NOS (077.9)
372.02 Acute follicular conjunctivitis
Conjunctival folliculosis NOS
Excludes: conjunctivitis:
adenoviral (acute follicular) (077.3)
epidemic hemorrhagic (077.4)
inclusion (077.0)
Newcastle (077.8)
epidemic keratoconjunctivitis (077.1)
pharyngoconjunctival fever (077.2)
372.03 Other mucopurulent conjunctivitis
Catarrhal conjunctivitis
Excludes: blennorrhea neonatorum (gonococcal) (098.40)
neonatal conjunctivitis (771.6)
ophthalmia neonatorum NOS (771.6)
372.04 Pseudomembranous conjunctivitis
Membranous conjunctivitis
Excludes: diphtheritic conjunctivitis (032.81)
372.05 Acute atopic conjunctivitis
372.06 Acute chemical conjunctivitis
Acute toxic conjunctivitis
Excludes: burn of eye and adnexa (940.0-940.9)

chemical corrosion injury of eye (940.2-940.3)
Use Additional E Code: to identify the chemical or toxic agent
372.10 Chronic conjunctivitis, unspecified
372.11 Simple chronic conjunctivitis
372.12 Chronic follicular conjunctivitis
372.13 Vernal conjunctivitis
372.14 Other chronic allergic conjunctivitis
372.15 Parasitic conjunctivitis
Code First: underlying disease as:
filariasis (125.0-125.9)
mucocutaneous leishmaniasis (085.5)
372.20 Blepharoconjunctivitis, unspecified
372.21 Angular blepharoconjunctivitis
372.22 Contact blepharoconjunctivitis
372.30 Conjunctivitis, unspecified
372.31 Rosacea conjunctivitis
Code First: underlying rosacea dermatitis (695.3)
372.33 Conjunctivitis in mucocutaneous disease
Excludes: ocular pemphigoid (694.61)
Code First: underlying disease as:
erythema multiforme (695.10-695.19)
Reiter's disease (099.3)
372.34 Pingueculitis
Excludes: pinguecula (372.51)
372.39 Other

Over the past 30 years, *ICD-9* has been updated to allow coding to the greatest extent known at the time of service. For example, in 2007, physicians reported 362.21 “retrolental fibroplasia” for retinopathy of prematurity. In 2007, the *ICD-9-CM* Coordination and Maintenance Committee included the need to expand the codes related to retinopathy of prematurity. The committee determined that retinopathy of prematurity (ROP) was a leading cause of blindness in children and that it was a serious vasoproliferative disorder involving the developing retina in premature infants.

Recognizing that when ROP becomes severe, it usually requires intervention, such as retinal photocoagulation, they noted that “Retrolental fibroplasia” was an older term which mainly applied to only cicatricial disease (i.e., when the retina is actually scarred). The committee also realized that “Retinopathy of prematurity” is the name of the disease used to describe the acute retinal changes seen in premature infants. Thus, new codes were proposed and accepted in the subcategory, “Other proliferative retinopathy,” to identify the stages of retinopathy of prematurity. The existing code 362.21 was changed from retrolental fibroplasia to cicatricial retinopathy of prematurity when the new codes were added.

The 2008 *ICD-9* included the following codes which continue in the 2012 *ICD-9*

Diagnosis Code	Description
362.20	Retinopathy of prematurity, unspecified
362.21	Retrolental fibroplasia (Cicatricial retinopathy of prematurity)
362.22	Retinopathy of prematurity, stage 0
362.23	Retinopathy of prematurity, stage 1
362.24	Retinopathy of prematurity, stage 2
362.25	Retinopathy of prematurity, stage 3
362.26	Retinopathy of prematurity, stage 4
362.27	Retinopathy of prematurity, stage 5

Even as these changes were being made, some physicians continued to use codes that were still valid, but no longer actually described the patient's actual problem or selected to add only the "unspecified" codes. For many physicians the diagnostic statements in the patients' progress notes today are very similar to those documented 20 years ago.

Plans for *ICD-10*? Better think about correctly using *ICD-9* first!

Although physicians should have been documenting and coding to the greatest extent known at the time of service, in our experience, the majority of physicians (especially those still using paper charts) have not included specific diagnostic statements in their progress notes. Most physicians have not updated their superbills to allow for selection of the *ICD-9* code that best described the patient's problem because of the desire to keep superbills to one page. In our chart reviews, we find that the diagnostic statements in the patient's progress note, operative report, diagnostic test interpretation, etc., do not "match" the diagnosis marked on the superbill and included on the claim for the specific date of service.

For physicians, we believe the most challenging part of transitioning to *ICD-10* will be the improvement needed in the diagnostic statement(s) in the patient's progress note. "Cats" "GLC" "PDR" "Conjunctivitis" "AMD" are not sufficient for coding to the greatest extent known at the time of service when using *ICD-9* codes. The next challenge will be how to create a superbill with enough flexibility to allow the physician to select the code that is specific to the greatest extent known about the patient's problem. Finally, coders will be challenged to obtain sufficient information to assign the appropriate *ICD-9* code(s).

Physicians can ease the transition by documenting specific diagnostic statements in their progress notes and utilize the most specific diagnosis code available. When using *ICD-9* codes that are "unspecified" or "not otherwise specified" (NOS), the claim indicates that there is insufficient information in the medical record to assign a more specific code. If the physician selects a code that includes "not elsewhere classifiable" (NEC), the physician is stating that there is no *ICD-9* code available that describes the condition.

For now, let's think about "GLC," the coder should be using the code for glaucoma unspecified (365.9). The physician's diagnostic statement does not indicate whether the patient has

- Primary open angle glaucoma (365.11)
- Chronic angle closure glaucoma (365.23)
- Pigmentary glaucoma (365.13)
- Corticosteroid-induced glaucoma (glaucomatous stage) (365.31)
- Pseudoexfoliation glaucoma (365.52)
- Other type of glaucoma

If the physician continues to use "GLC" on or after October 1, 2011, the coder cannot assign the appropriate type of glaucoma or the appropriate glaucoma stage and will also be forced to use unspecified codes 365.9 and 365.70. Not only is this a problem while we continue to use *ICD-9*, we are concerned how physicians are going to transition to *ICD-10* if they continue to use unspecified diagnostic statements in patient progress notes, operative reports, diagnostic tests, etc.

ICD-10 Coding

The greatest change for physicians coding glaucoma in *ICD-10* is the need to specify laterality, e.g., right eye, left eye, bilateral. In fact, laterality is one of the reasons for the increase in the number of codes available. *ICD-10* also requires additional specificity by combining some diagnostic statements into a single code while exploding a single *ICD-10* into multiple codes.

Are you subconsciously ignoring the future?

Many in the physician community believe it will be easy to transition their current unspecified *ICD-9* codes to unspecified *ICD-10* codes. In our opinion, this will be a grave mistake. As reimbursement moves away from payment for quantity to payment for quality, we believe that in addition to meeting quality standards, physicians will need to use specific *ICD-10* codes that paint the picture to show what is going on with the patient. This specificity will assist the payer in determining medical necessity for visits, diagnostic tests, and procedures.

According to the American Academy of Professional Coders, some payers have already decided they will reject claims that include an unspecified code as the primary diagnosis for a service included on the claim. If this happens, it very well may be that the rejection will not be a denial and may not have an appeals process. In this scenario, the practice will need to determine the specific *ICD-10* code and submit a new claim. In addition to recoding, we believe the physician will also have to make an addendum to the patient's medical record for that date of service to indicate the appropriate diagnostic statement for the patient's problem to support the diagnosis code reported on the claim.

Think all of this is far-fetched and being written by a crazy woman? We are already seeing Medicare Local Coverage Decisions (LCD) with different frequency standards for diagnostic tests based on the patient's diagnosis. The frequency for one diagnosis may allow payment for the test on an annual basis, yet payment for another diagnostic test may allow payment for the test performed once a month. Most payers include a list of "approved" diagnosis codes in their medical policies. Payers like the idea of data-mining. They can track detailed utilization data through the claims processing system.

In some states, ophthalmologists have received notices from an insurer stating they are being disenrolled from their Medicare Advantage Plan. The insurer notes in the letter that according to their contract with the Centers for Medicare & Medicaid Services' they have sufficient ophthalmologists to meet network access and geographic requirements. These letters explain that their decision to discontinue the physician/practice's participation in the Advantage Plan was based on a "review of the practice's efficiency, utilizing a claims-based, episode-of-care methodology, and adherence to evidence-based guidelines as available."

The letter explains that it is not just the direct physician allowable charges, but the consideration of treatment options: prescribed pharmaceuticals, diagnostic tests (including imaging and laboratory services), choice of consultants, and selection of facilities that contribute to the cost of treating the patient during an episode of care. What it all boiled down to was when compared with other ophthalmologists in their network, it was costing the plan more for these physician/practices to treat specific problems.

Insurers are analyzing their expenditures now. We are hopeful with additional specificity in diagnosis coding, the analysis will allow for better comparison based on the patient's status and not just the cost for a general diagnostic category. It seems reasonable that the cost to treat a glaucoma-suspect patient who has open angles with borderline findings, low risk is probably lower than treating a patient with primary open angle glaucoma with moderate damage.

***ICD-10* – Have you started your preparations? Time is Flying By! October 1, 2013 is only 25 Months Away**

Think First – 5010

Before we even think about *ICD-10*, you need to consider the practice's ability to submit claims using the 5010 electrotonic claim standard. As of January 1, 2012, all claims submitted in 4010 format will be rejected. Practices having 10 or more employees must file electronic claims; you cannot drop claims to paper while you scramble to catch up to the 5010 standard.

The first question is whether the vendor for your practice management system and clearinghouse has tested with Highmark and been approved for production in the 5010 Errata version. If they have successfully tested, they can move to production whenever they are ready. **Vendors** must fax or mail a list of their clients' National Provider Identification Number (NPI) or Provider Transaction Access Number (PTAN) on letterhead to Highmark Medicare Services EDI in order to move the practice to production.

Another question is whether the vendor has explained changes in the data required for the 5010 format. For example, physicians are required use the appropriate 9-digit ZIP code (ZIP + 4) in the electronic equivalents of Items 32 and 33:

Item 32	Enter the name and address, and ZIP +4 code of the facility patient's home, or physician's office based on the place of service used in Item 24b. this is a Required field
Item 33	Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number. This is a required field.

Don't forget, if you have an optical dispensary, the patient's home address needs to be included in the electronic equivalent of Item 32. In this scenario, when filing claims for covered eyeglasses and contact lenses, you will need the patients' ZIP+4 for DMEPOS claims.

The practice should have a process for obtaining the ZIP+4 for all addresses. Once in the 5010 format, ZIP+4 should be added to the facility database. Since most of us haven't gotten in the habit of using ZIP+4, for me the easiest way to obtain the information is through the United States Postal Service (USPS) website at http://zip4.usps.com/zip4/welcome.jsp

ICD-10

The compliance date for implementation of the *ICD-10-CM* is **October 1, 2013** for all covered entities as defined by the Health Insurance Portability and Accountability Act (HIPAA). *ICD-10* is NOT an update to *ICD-9*, it is an entirely new coding system! *ICD-9-CM* includes approximately 16,000 codes; *ICD-10-CM* includes approximately 70,000 codes. *ICD-10* codes are longer and use more alpha characters

Don't forget, this isn't just a Medicare change, the entire health care system will transition to *ICD-10* on 10/1/2013. This transition affects physicians, hospitals, insurers, all government payers (including Medicaid), hospices, pharmacies, home health agencies, clearinghouses, etc. Many economists have estimated that the health care system will spend more money transitioning to *ICD-10* than we spent getting ready for Y2K!

Have you started your preparations?

Have you performed an assessment of the practice? (Not all-inclusive)

- *ICD-9* Codes
  Who in the practice uses *ICD-9* codes?
  How do they use the codes?
  Who will need training?
  What is the extent of training they will need?
  Preferred method of training?
  Budget for training?

- How specific are the diagnostic statements in patient medical records?
  Is physician training needed? If yes, who will train?
  Can technicians help physicians provide complete diagnostic statements?

- What is the status of your current practice management system?
  Physicians need to prepare to run two (2) diagnosis coding systems beginning 10/1/2013. Determination of when to use *ICD-9* and *ICD-10* is based on the **date of service**, not when the claim is filed.

  Many scenarios will exist after October 1, 2013 when physicians will need to use *ICD-9*. For example, a hospital inpatient is admitted 9/27/2013 and discharged 10/3/2013. At this time, in this scenario, it appears we will file two claims. The first claim will include dates of service 9/27/2013 through 9/30/2013; the second claim will include dates of service 10/1/2013 through 10/3/2013.

  Another example will be a patient covered by an insurance plan that is primary to Medicare. The primary insurer's payment for dates of service on or before 9/30/2013 may not be received until on or after 10/1/2013. The MSP claim must be filed with *ICD-9* codes even though the claim is being submitted after the transition to *ICD-10*.

  Although we try to get every claim submitted to the correct payer, there are always situations when the claim is submitted to one insurer only to find out that the claim should have been submitted to another payer. If the date of service is on or before 9/10/2013, you will still use *ICD-9* diagnosis codes.

  The question you should be asking your vendor is whether your current practice management system is capable of running two complete sets of diagnosis codes. Is it time to upgrade, add more memory, etc.

- Will the practice be using paper charts or an electronic health record (EHR)?

- Will the practice try to use paper superbills or electronic charge capture?

As we move forward, I think we can count on one of two things happening:

- The Mayans had it right about 12/21/2012 and *ICD-10* won't be needed!
- Physicians and payers will be ready for *ICD-10* by October 1, 2013 or accounts receivables will go sky-high!