ICD-10

HOW to TRANSITION your PEDIATRIC PRACTICE

WITHOUT FEELING LIKE YOU’VE BEEN V0490XA*

* ICD-10 CODE FOR HIT BY A MAC TRUCK
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WHAT’S THE CODE FOR ICD-10 SUCCESS?

Ok, there isn’t really a code for ICD-10 success but if there was it would be plan, plan, plan. The majority of practices have done little or nothing to prepare for ICD-10. This could be disastrous. An effective transition requires planning and preparation to mitigate the potential financial impact as much as possible.

What Is ICD-10?
On October 1, 2015, medical coding as we know it will change forever. Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must be compliant with ICD-10 on that date—not just those who submit to Medicare and Medicaid.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Codes are 3-5 characters</td>
<td>Codes are 3-7 characters</td>
</tr>
<tr>
<td>Approximately 14,000+ codes</td>
<td>69,000+ codes</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V) and characters 2-5 are numeric</td>
<td>First character is alpha, characters 2 and 3 are numeric, 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>Difficult to analyze data due to nonspecific codes</td>
<td>Expanded to allow more specificity and accuracy resulting in improved data analysis</td>
</tr>
<tr>
<td>No other country uses ICD-9—limiting interoperability with other countries</td>
<td>United States is one of last major countries to transition to ICD-10</td>
</tr>
</tbody>
</table>

Table 1. Differences Between ICD-9 and ICD-10
ICD-10 will impact many areas of your practice and touch every employee. And it will affect your pediatric practice in unique ways. Advanced preparation is the key to success.

The first thing to do before you start planning for your ICD-10 transition is to understand what ICD-10 is and how it differs from ICD-9 (table 1). Specifically, you need to know what aspects of ICD-10 may impact your pediatric documentation, coding, and billing.

Laterality
Unlike ICD-9, ICD-10 specifies left, right, and bilateral. For example, a patient presents with a cyst on his or her eyelid. To properly report the ICD-10 code for this condition, physicians must document whether the cyst is on the right or left lid. They must also specify upper versus lower lid.

Although ICD-10 provides an option for ‘unspecified eye,’ payers will likely not accept this code (H02.829) because it provides very little clinical information. Physicians should crosswalk any diagnoses on their superbill from ICD-9 to ICD-10 to determine whether any of the conditions require laterality. Laterality is a common theme throughout ICD-10, so it’s likely that at least one condition on a superbill will be affected.

Anatomical Site or Location
ICD-10 requires far more detail in terms of the location of an injury or condition. For example, a patient presents with abdominal pain. Physicians must document precisely where the pain is occurring (i.e., upper abdominal, lower abdominal, pelvic, periumbilical, and so forth).

Physicians should thoroughly read the ICD-10 code descriptions pertinent to pediatrics to understand what type of clinical detail is required.
Combination Codes
ICD-10 includes hundreds of combination codes (i.e., codes that link symptoms, manifestations, or complications with a particular diagnosis). For example, E10 denotes Type 1 Diabetes Mellitus; E10.2 is Type 1 Diabetes Mellitus with kidney complications. Furthermore, E10.22 denotes Type 1 Diabetes Mellitus with diabetic chronic kidney disease.

To report combination codes correctly, documentation must clearly indicate the presence of the symptom, manifestation, or complication along with the pertinent condition to which it corresponds. Documentation must also link the two together (e.g., Diabetes with kidney disease).

Type of Encounter
Some ICD-10 codes specify whether the encounter is initial, subsequent, or sequela. For example, a patient presents with a laceration of his or her right hip tendon. Physicians must document the type of encounter so coders can assign the 7th (and final) character in the ICD-10 code. An initial encounter is one in which the patient receives initial active treatment. A subsequent encounter is one in which a patient receives routine care during the healing or recovery phase. A sequela encounter is one in which a patient receives treatment for complications or conditions that arise as a direct result of a condition. The 2014 ICD-10 Official Guidelines for Coding and Reporting provides examples of each.

The type of encounter is required for valid submission of certain codes. Those working in the orthopedic specialty should pay close attention to the 7th character, as it may also include other important information, such as the type of healing (i.e. routine, delayed, nonunion, or malunion).
ICD-10 Coding Guidelines
Physicians who assign their own codes must—at a minimum—read the CDC’s 2014 ICD-10 Official Guidelines for Coding and Reporting. This document is a treasure trove of information that includes little known facts about the new coding system physicians could easily overlook. For example, ICD-10 requires inclusion of a placeholder character ‘X’ for certain codes to allow for future expansion. Code category T36-T50 (poisoning by, adverse effects of, and underdosing of drugs, medications, and biological substances) is one example.

ICD-10 codes can range in length from three to seven characters, including placeholders. Only complete codes will be considered valid. Review the guidelines for more information about coding conventions and diagnostic reporting for outpatient services.

Changes for Pediatrics
The transition to ICD-10 could have a particularly significant impact on your pediatric practice’s bottom line, according to new research conducted by the University of Illinois at Chicago.

Using a Web-based tool developed at the university, researchers analyzed 2010 Illinois Medicaid data and discovered that 26 percent of pediatric ICD-9-CM codes have convoluted mapping to ICD-10-CM. This means that converting these codes to the new coding system is either complex or simply difficult, oftentimes demanding documentation specificity.

In a specialty that already has a low financial margin, ensuring thorough documentation practices is critical. Many of the diagnoses that pediatricians frequently report are now much more specific—if pediatricians continue to document as they do today, these diagnoses will map to unspecified codes that payers may not reimburse.

Pediatricians should focus on the following diagnoses, which will require additional documentation in ICD-10-CM:

✔ Asthma (J45.-). In ICD-10-CM, the documentation of asthma is not sufficient. Instead, pediatricians must specify the type of asthma
(i.e., mild intermittent, mild persistent, moderate persistent, severe persistent, or other) as well as if the asthma is uncomplicated, with exacerbation, or with status asthmaticus. An additional code is necessary to denote the cause of the asthma (e.g., exposure to environmental tobacco smoke, history of tobacco use, or occupational exposure to environmental tobacco smoke).

The National Heart Lung and Blood Institute publishes guidelines regarding the classification of asthma and clinical criteria. See p. 5 of the Asthma Care Quick Reference Guide, and be sure to stick to these definitions.

**Otitis media (H65.- to H67.-).** In ICD-10-CM, documentation of *otitis media* is not sufficient. Instead, pediatricians must specify the type of otitis media (e.g., serous, sanguinous, suppurative, allergic, mucoid), the severity (i.e., acute, chronic, subacute, or recurrent), and laterality (i.e., left, right, or bilateral). Additional codes must be assigned to denote the presence of any associated perforated tympanic membrane, as well as any environmental factors (e.g., tobacco use, tobacco dependence, or history of tobacco use).

**Well-child exam (Z00.11- and Z00.12-).** ICD-9-CM includes one code for a well-child exam (V20.2 or V20.3x, depending on the child’s age). ICD-10-CM provides more options because it also distinguishes between *with abnormal findings* and *without abnormal findings*. Be sure to document the specific abnormal finding, when present.

The distinction between *with* and *without* abnormal findings could benefit pediatric practices because it may bolster support for providers to be able to separately bill for an evaluation and management service. For example, if during a well-child exam, a provider uncovers, evaluates, and treats an ear infection, he or she may be able to bill for the well-child check with abnormal findings, as well an office visit with a modifier -25. Physicians should clearly document the treatment and evaluation of any abnormal findings that they discover. Providers should check with their insurance carriers before implementing this process.
How to Transition Your Pediatric Practice

- **Encounter for immunization (Z23).** In ICD-9-CM, each immunization procedure code required a corresponding diagnosis code indicating the purpose for the immunization. In ICD-10-CM, pediatricians simply report Z23 with each immunization. This simplifies the process and creates less work.

- **Diabetes (E08.- to E13.-).** The codes for diabetes have greatly expanded in ICD-10-CM and now include the type of diabetes (i.e., type 1, type 2, drug- or chemical-induced, due to an underlying condition [specify the condition], or gestational) and any body systems affected and/or complications. An additional code is necessary to denote the use of insulin.

- **Underdosing (Z91.12- or Z91.13-).** Underdosing is a new concept in ICD-10-CM that captures instances in which a patient takes less of a medication than what is prescribed. Pediatricians must specify whether the underdosing is intentional or unintentional. If intentional, specify whether it’s due to financial hardship or some other reason. If unintentional, specify whether it’s because of an age-related debility or some other reason. Pediatricians may frequently report an intentional underdosing if parents cannot afford to provide medications for their children. These codes are important in terms of collecting data that insurers can use to provide programs to help individuals pay for medication or make suggestions for lower-cost drugs.

- **Injuries (various ICD-10-CM codes).** ICD-10-CM codes for injuries are organized by anatomical site. Pediatricians must document the site of the injury and the episode of care (i.e., initial, subsequent, or sequelae). When coding for injuries, it is important to report external cause codes to explain how the injury occurred. These codes denote the following: External cause (i.e., how the injury was sustained), place of occurrence (i.e., where the injury occurred), activity (i.e., what the patient was doing at the time of the injury), and external cause status (i.e., leisure activity).
✓ Bronchitis (J20.-, J40-J42, J44.-, J47.0, J68.0). Pediatricians must document acuity (i.e., acute, chronic, or subacute), as well as the causal organism (e.g., respiratory syncytial virus or metapneumovirus). If the cause of the bronchitis is unknown (as is often ultimately the case for patients with an initial presentation), it may be sufficient to report an unspecified code. Providers should not change their clinical decision-making process simply to obtain greater specificity. Providers should only perform a culture when warranted.

✓ Feeding problems in newborns (P92.-). Pediatricians must document the specific type of feeding problem (e.g., slow feeding, overfeeding, or regurgitation and rumination). Unlike ICD-9-CM, which only included two codes (779.34, failure to thrive, and 779.31, feeding problem), ICD-10-CM includes a separate code for each problem.

Strategies for Success
Review each of the code categories listed above to familiarize yourself with code options. Also review CMS references for pediatricians. Laterality plays an important role for many of these diagnoses, and pediatric practices could take a significant financial hit if this information is not specified.
STEP 1: GET EDUCATED

Why Train
Don’t assume you can send your coder or biller to training and call it done. ICD-10 affects virtually everyone in the practice in some way. It is important for everyone to learn how ICD-10 may affect their role—only then can you plan education and training accordingly.

Practice Manager
- New Policies
- Updates to Payer Contracts
- Budgeting/Financial Planning
- New Forms/Software Changes

Front Desk
- Prior Authorizations

Billing & Coding
- Payer Changes
- Coding Changes
- Software Changes

Clinical Providers
- Coding Changes
- Documentation Changes
- Software Changes

Educational Resources
Get everyone up on the basics with these resources:

- www.kareo.com/icd-10
- www.roadto10.org/
- www.cms.gov/ICD10
- www.ama-assn.org
- www.himss.org
- www.icd10watch.com
- www.aapc.com
Order the ICD-10 coding handbook for training and evaluating the equivalent codes for your ICD-9 codes. Here are a couple of good tools:

- **ICD-10 2014 Codebook** from the AMA
- **ICD-10 Mappings 2014** from the AMA

**Who to Train**

One cost effective strategy is to send an individual in the practice, or in a larger practice a group of individuals, to training (online or in person). Then have trained staff come back and train others.

This is a great solution for small practices. Send your biller or coder to training (especially anyone who needs to update certification) and then have that person come back and train people in other roles on just the tasks that are pertinent to them.

In larger practices it might be all certified coders along with one person from each group (a front desk person, a nurse, a doctor, etc.). Larger practices might also consider having someone come in to do training on site for everyone. There is a tipping point where this is actually more cost effective.

**When to Train**

ICD-10 training should begin as soon as possible. Not only does this give staff members more time to adjust to the new code set, but it also helps to mitigate any productivity losses during the training period. Training can be incremental and staggered so as not to affect daily responsibilities, particularly in smaller practices.

Proactive training also ensures that practices can find a course with a certified and experienced trainer. Currently, there is a shortage of courses and trainers.
Where to Find Training

AHIMA, the American Academy of Professional Coders, and a variety of other educational providers offer training that is specific to coders, physicians, or office/clinic (non-coding) staff members. Opportunities range from online learning to audio conferences to live events, and more. The cost and time commitment varies based on the complexity of training. For a certified coder it may require as much as two days and cost as much as $1,500. However, a short, half-day online training for a biller may only be $250. Planning ahead can also help you plan for these costs appropriately.

Physicians may be able to get the education that need from medical societies and software vendors. There are even CME courses available in some cases.

Talk to your practice management, billing, and EHR vendors about software changes, what training will be available for users, and when it will occur.
STEP 2: REVIEW CODING & DOCUMENTATION

Documentation Improvement
Providers may not want to hear this, but the single biggest issue to be addressed in transitioning may be the increased need for documentation. After October 1, 2015, the old order for documentation standards will no longer suffice. The new order requires greater detail.

The truth is that many physicians do not document for specificity with current ICD-9 codes and this will make implementation of ICD-10 coding frustrating. To make it a little easier, start making changes now!

Coders and billers can’t diagnose or assume a diagnosis. The clinicians must specifically document the presenting symptoms or chronic and acute conditions in detail. Providers will need to understand the expanded code descriptors, and these should be mirrored in their medical record dictation/documentation.

Think about hiring a clinical documentation improvement (CDI) specialist or a consulting company to formally audit your documentation. A CDI specialist is someone—often a nurse or certified coder with a clinical background—who helps physicians improve their documentation so it accurately reflects patient severity of illness and meets regulatory requirements. Although ICD-10 won’t require physicians to change the way they document, it does require you to be more mindful of specificity. Accountable care organizations (ACOs) are already engaging CDI specialists to ensure that the physicians in their affiliated practices are documenting appropriately—you can hire these specialists, too!
How to Transition Your Pediatric Practice

Complete and detailed documentation helps physicians organize their observations and examination, justify their treatment plan, support the diagnoses, and document patients’ progress and outcomes. The medical record is a vehicle of communication for providers to evaluate, plan, and monitor patients’ care and treatment. Documentation also supports severity of illness, length of hospital stay, and risk of morbidity/mortality data.

**Code Mapping**

In addition to improving documentation, providers, coders, and billers need to get comfortable with the new codes. Code mapping is a technique that can help you prepare for ICD-10. By mapping your most commonly used ICD-9 codes to their ICD-10 equivalents you can get familiar with your new codes before the transition.

**Code Mapping adds five (5) key benefits to your practice.**

1. It enables you to gain an understanding of the structure of the ICD-10 codes specific to your specialty.
2. It helps you understand the equivalent ICD-10 codes and determine if more specific documentation is required.
3. Once you start using ICD-10, it will improve the accuracy of your billing.
4. It guides changes to documents and forms.
5. It helps you plan and customize your staff training.

The complexity of your mapping process will depend largely on your unique practice and/or specialty. For some, it will be straightforward because of the limited number of codes currently employed by the practice (i.e., pediatrics). For others, it will be more complex because of the current range of codes utilized to diagnose patients (i.e., internal medicine).
Sample Code Map

Table 2 is an excerpt from a code map for a pediatrics practice. Depending on the complexity of your practice, it may be more appropriate to identify the top 50 or even top 100 codes to map.

<table>
<thead>
<tr>
<th>Rank</th>
<th>ICD-9 Codes</th>
<th>ICD-9 Diagnosis Description</th>
<th>ICD-10 Codes</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>V20.2</td>
<td>Routine infant or child health check</td>
<td>Z00.121</td>
<td>Encounter for routine child health examination with abnormal findings (use additional codes to identify abnormal findings)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z00.129</td>
<td>Encounter for routine child health examination without abnormal findings</td>
</tr>
<tr>
<td>2</td>
<td>V72.19</td>
<td>Other examination of ears and hearing</td>
<td>Z01.10</td>
<td>Encounter for examination of ears and hearing without abnormal findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z01.110</td>
<td>Encounter for hearing examination following failed hearing test</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z01.118</td>
<td>Encounter for examination of ears and hearing with other abnormal findings</td>
</tr>
<tr>
<td>3</td>
<td>465.9</td>
<td>Acute upper respiratory infection of unspecified site</td>
<td>J06.9</td>
<td>Acute upper respiratory infection, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>J39.8</td>
<td>Other specified diseases of upper respiratory tract</td>
</tr>
</tbody>
</table>

Table 2. Sample Code Map Excerpt
STEP 3: ANALYZE YOUR WORKFLOW

ICD-10 could affect many aspects of your practice’s workflow. You will need to evaluate your current workflow to look for areas where you need to make updates or changes and identify potential delays.

Document Review
The first change in process took place in January 2014 with the release of the new CMS 1500 v02/12 paper claim form. This form was required for CMS claims starting on April 1, 2014. Other payers will transition at their own pace so you may be using two different versions on the CMS 1500 form for a period of time.

Depending on how automated your processes are, there could be other printed forms that need to be updated. So, do a form review and look for necessary changes to accommodate ICD-10. Some of the forms that may need to be revised include paper superbills, referral forms, x-ray forms, laboratory forms, authorization forms, and any other forms that use diagnosis codes. If you are still doing many of these tasks manually, this is a good time to consider a switch to an electronic option. It can eliminate or reduce the need to update and reorder many common paper forms.

Workflow Review
This is a significant change to the way you document and code visits and bill payers. As with any change in the clinical process, there may be delays as providers get used to changing documentation and coding. This could be true for billers and coders as well. They will probably find that they have to request additional information from providers and spend a little more time completing claims.
In addition, since there is no way to know how well your payers will do with the change, your billing staff could also be spending more time on claim follow up for a period of time. It’s worth your while to plan for an increase in workload for billing staff for at least a short period of time.

As you prepare for the change, keep these potential workflow issues in mind. Depending on the comfort level of providers and staff, it may be wise to reduce patient visits for a month or two while you adapt. If you do choose to do this, be sure to factor the cutback into your financial planning (See Step 4: Financial Planning).
STEP 4: FINANCIAL PLANNING

ICD-10 will impact your revenue—both now and after the transition. There is more to this change than training and code mapping—your practice may not survive without thoughtful financial planning.

There are three basic pieces to your ICD-10 financial planning:

1. Planning for added expenses related to training and preparing for the transition.

2. Identifying what you will need for cash reserves to protect your practice in the event of a reduction in revenue and productivity. You’ll need to save that money or work with your bank to establish a line of credit.

3. Looking at ways to contain costs and reduce expenses in case you do see a revenue shortfall.

ICD-10 Budget

Because ICD-10 requires training, updates to forms, changes to workflow, and the purchase of new resources, it needs a budget. It doesn’t have to be fancy, but take some time to create a spreadsheet and list out all the potential expenses (table 3). Can you accommodate them in your normal monthly budget or do you need to set aside some extra funds to cover those costs. The sooner you figure it out the more time you have to spread out the expenses. Remember to look at both your practice costs and the costs associated with training each employee as appropriate.

Cash Reserves

Many experts are suggesting that you should expect to see a reduction in productivity and revenue for about three months of up to 50% (and some say as much as six months). You’re a small business with bills to pay so you need to plan for a potential loss of revenue. If you can’t pay your rent, utilities, and employees, it will be hard to keep the doors open.
The more prepared and well trained you are, the less impact ICD-10 should have, but you can’t predict how the transition will go with your payers. While your own staff may do fine, there could be delays with payers that you can’t do anything about. If you can set aside enough cash reserves (or qualify for a line of credit) before October, 2015, then you’ll be prepared for whatever happens. Use the following steps to plan:

1. Total your last 12 months of revenue and divide by 12 to get your average revenue per month.
2. Divide your average revenue per month by two.
3. Multiply that number by three.

<table>
<thead>
<tr>
<th>Expense</th>
<th>Example</th>
<th>Staff 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>Workbooks</td>
<td>$99</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Salary</td>
<td>$120</td>
<td></td>
</tr>
<tr>
<td>Temp Staff (to cover for staff during training)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Overtime</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Lost Revenue (if you close the office for training)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Forms</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Additional Coding Books</td>
<td>$99</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td><strong>$768</strong></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Sample Budget Spreadsheet
Cost Containment
Setting aside reserves or getting a line of credit for ICD-10 may not be enough. When you combine additional expenses for several months with loss of revenue for up to three months or more, you might want to look at how you can cut expenses in your business.

Managing expenses and containing costs is actually something you should do on a regular basis as part of your annual budgeting. Here are several areas to review and consider:

1. **Reduce Utilities.** You should always be looking at ways to minimize costs for electricity, Internet, phones, etc. Watch for competitive rates and special offers that may reduce these expenses.
2. **Review Contracts and Leases.** Review all your vendor contracts and leases each year and get competitive quotes from at least two or three other vendors. Also, look for ways to reduce usage for printers, copiers, and other equipment. With more automated solutions, some of these items may become obsolete.

3. **Automate or Outsource Processes.** If you are still doing many practice management, billing, and clinical tasks manually, now is the time to automate or outsource. For example, manually processing paper statements can easily cost two or three times what it costs to use a statement service. Using a medical billing service is often a less expensive alternative to having full time billing staff and can improve your overall collections. According to the Medical Group Management Society, using an integrated practice management and EHR solution can increase your revenue by almost 10% while also reducing expenses for many supplies and time spent on previously manual tasks.

You may wonder why the largest expense of all—staffing costs—is not included above. It’s because there are some special considerations around staffing with regard to ICD-10. On the one hand, this is probably not the time for overtime, raises, or bonuses. Wait until after January 2016 to look at that and explain to staff the reasons why. Conversely, this is also not the time to make staff cutbacks. Generally when looking at cost reductions, this would be the first place to consider. But you’ll probably need all your resources and then some to manage this transition. Even with the addition of new technology, any staff changes should also probably wait until 2016 when things have settled down.
STEP 5: TEST, TEST, TEST

Although CMS recommended testing in late 2013, most payers and clearinghouses were not ready. It is unclear at this time when all healthcare providers will be able to test ICD-10 claims.

Some clearinghouses, software vendors, and healthcare providers who submit direct to Medicare have begun testing. The first testing phase was in early March 2014. Testing dates for all healthcare providers have not yet been released.

Your practice management and billing software vendor should be preparing the software for the change so you can test claims when the time comes. Your vendor will likely contact you when clearinghouses and payers are ready to begin testing claims.

Use this time to get your staff trained and prepared so they are ready when the testing period begins. You won’t be able to create test claims if no one knows how to document or code to create superbills and claims.

When everything is ready, you’ll want to be able to both submit the test claims and receive responses and feedback from your clearinghouses and payers. This will help you identify problem areas that you need to work on before you submit a real claim on or after October 1.
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