ICD-10-CM For OB-GYN

BY

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I am providing some common ICD-9-CM codes used in OB/GYN. This guide does not constitute official coding standards and guidelines. This guide is NOT policy. This guide is provided free of charge by the author, Steve Verno and it was created as a courtesy to a fellow coder or provider. This guide does not take the place of coding or published coding manuals and current coding guidelines. This guide does NOT discuss ICD-10-PCS.
Obstetrics and Gynecology ICD-10-CM Coding Guidelines:

I am providing the current 2014 ICD-10-CM coding guidelines, word for word, for this specialty as written in the guidelines which are available on the CDC website. I do not provide interpretation of any guideline. Any questions should be directed to the Centers for Disease Control.

5) Sepsis due to a postprocedural infection
   (a) Documentation of causal relationship
       As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

   (b) Sepsis due to a postprocedural infection
       For such cases, the postprocedural infection code, such as, T80.2, Infections following infusion, transfusion, and therapeutic injection, T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection

15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)

a. General Rules for Obstetric Cases

1) Codes from chapter 15 and sequencing priority Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1, Pregnant state, incidental, should be used in place of any chapter 15 codes. It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.

2) Chapter 15 codes used only on the maternal record Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.

3) Final character for trimester
   The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code it is because the condition always occurs in a
specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one.

Assignment of the final character for trimester should be based on the provider’s documentation of the trimester (or number of weeks) for the current admission/encounter. This applies to the assignment of trimester for pre-existing conditions as well as those that develop during or are due to the pregnancy. The provider’s documentation of the number of weeks may be used to assign the appropriate code identifying the trimester.

Whenever delivery occurs during the current admission, and there is an “in childbirth” option for the obstetric complication being coded, the “in childbirth” code should be assigned.

4) Selection of trimester for inpatient admissions that encompass more than one trimester

In instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester of the discharge. If the condition developed prior to the current admission/encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission/encounter should be assigned.

5) Unspecified trimester

Each category that includes codes for trimester has a code for “unspecified trimester.” The “unspecified trimester” code should rarely be used, such as when the documentation in the record is insufficient to determine the trimester and it is not possible to obtain clarification.

6) 7th character for Fetus Identification

Where applicable, a 7th character is to be assigned for certain categories (O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69) to identify the fetus for which the complication code applies.

Assign 7th character “0”:

For single gestations

• When the documentation in the record is insufficient to determine the fetus affected and it is not possible to obtain clarification.
• When it is not possible to clinically determine which fetus is affected.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.
2) **Prenatal outpatient visits for high-risk patients**

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

3) **Episodes when no delivery occurs**

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

4) **When a delivery occurs**

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient’s admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis.

5) **Outcome of delivery**

A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

c. **Pre-existing conditions versus conditions due to the pregnancy**

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

d. **Pre-existing hypertension in pregnancy**

Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease.
e. Fetal Conditions Affecting the Management of the Mother

1) Codes from categories O35 and O36

Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother’s record.

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.

No code from Chapter 16, the perinatal codes, should be used on the mother’s record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

f. HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

g. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned a code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, first, followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4.

h. Long term use of insulin

Code Z79.4, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.

i. Gestational (pregnancy induced) diabetes

Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Codes for gestational diabetes are in subcategory O24.4, Gestational diabetes mellitus. No other code
from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4

The codes under subcategory O24.4 include diet controlled and insulin controlled. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. Code Z79.4, Long-term (current) use of insulin, should not be assigned with codes from subcategory O24.4.

An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

j. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium
When assigning a chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis. If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction(s) should also be assigned as additional diagnoses.

k. Puerperal sepsis
Code O85, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A40, Streptococcal sepsis, or A41, Other sepsis, should not be used for puerperal sepsis. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

l. Alcohol and tobacco use during pregnancy, childbirth and the puerperium
1) Alcohol use during pregnancy, childbirth and the puerperium
Codes under subcategory O99.31, Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses alcohol during the pregnancy or postpartum. A secondary code from category F10, Alcohol related disorders, should also be assigned to identify manifestations of the alcohol use.

2) Tobacco use during pregnancy, childbirth and the puerperium
Codes under subcategory O99.33, Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses any type of tobacco product during the pregnancy or postpartum. A secondary code from category F17, Nicotine dependence, should also be assigned to identify the type of nicotine dependence.
m. Poisoning, toxic effects, adverse effects and underdosing in a pregnant patient
A code from subcategory O9A.2, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate injury, poisoning, toxic effect, adverse effect or underdosing code, and then the additional code(s) that specifies the condition caused by the poisoning, toxic effect, adverse effect or underdosing.
See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects.

n. Normal Delivery, Code O80

1) Encounter for full term uncomplicated delivery
Code O80 should be assigned when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

2) Uncomplicated delivery with resolved antepartum complication
Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of the admission for delivery.

3) Outcome of delivery for O80
Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

o. The Peripartum and Postpartum Periods

1) Peripartum and Postpartum periods
The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Peripartum and postpartum complication
A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6 week period
Chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related.
4) Admission for routine postpartum care following delivery outside hospital
When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code Z39.0, Encounter for care and examination of mother immediately after delivery, should be assigned as the principal diagnosis.

5) Pregnancy associated cardiomyopathy
Pregnancy associated cardiomyopathy, code O90.3, is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Code O90.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a woman who did not have pre-existing heart disease.

p. Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

1) Code O94
Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium, is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

2) After the initial postpartum period
This code may be used at any time after the initial postpartum period.

3) Sequencing of Code O94
This code, like all sequela codes, is to be sequenced following the code describing the sequelae of the complication.

q. Termination of Pregnancy and Spontaneous abortions

1) Abortion with Liveborn Fetus
When an attempted termination of pregnancy results in a liveborn fetus, assign code Z33.2, Encounter for elective termination of pregnancy and a code from category Z37, Outcome of Delivery.

2) Retained Products of Conception following an abortion
Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy are assigned the appropriate code from category O03, Spontaneous abortion, or codes O07.4, Failed attempted termination of pregnancy without complication and Z33.2, Encounter for elective termination of pregnancy. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.
3) Complications leading to abortion
Codes from Chapter 15 may be used as additional codes to identify any documented complications of the pregnancy in conjunction with codes in categories in O07 and O08.

r. Abuse in a pregnant patient
For suspected or confirmed cases of abuse of a pregnant patient, a code(s) from subcategories O9A.3, Physical abuse complicating pregnancy, childbirth, and the puerperium, O9A.4, Sexual abuse complicating pregnancy, childbirth, and the puerperium, and O9A.5, Psychological abuse complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate codes (if applicable) to identify any associated current injury due to physical abuse, sexual abuse, and the perpetrator of abuse.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment.

16. Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)
For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes

a. General Perinatal Rules

1) Use of Chapter 16 Codes
Codes in this chapter are never for use on the maternal record. Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record. Chapter 16 codes may be used throughout the life of the patient if the condition is still present.

2) Principal Diagnosis for Birth Record
When coding the birth episode in a newborn record, assign a code from category Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth. If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital. A code from category Z38 is used only on the newborn record, not on the mother’s record.

3) Use of Codes from other Chapters with Codes from Chapter 16
Codes from other chapters may be used with codes from chapter 16 if the codes from the other chapters provide more specific detail. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established. If the reason for the encounter is a perinatal condition, the code from chapter 16 should be sequenced first.

4) Use of Chapter 16 Codes after the Perinatal Period Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient’s age.

5) Birth process or community acquired conditions
If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned.

6) **Code all clinically significant conditions**

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:
- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs

**Note:** The perinatal guidelines listed above are the same as the general coding guidelines for “additional diagnoses”, except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs.

b. **Observation and Evaluation of Newborns for Suspected Conditions not Found**

Reserved for future expansion

c. **Coding Additional Perinatal Diagnoses**

1) **Assigning codes for conditions that require treatment**

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

2) **Codes for conditions specified as having implications for future health care needs**

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

**Note:** This guideline should not be used for adult patients.

d. **Prematurity and Fetal Growth Retardation**

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P07, Disorders of
newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age. Codes from category P05 should not be assigned with codes from category P07.

When both birth weight and gestational age are available, two codes from category P07 should be assigned, with the code for birth weight sequenced before the code for gestational age.

e. Low birth weight and immaturity status
Codes from category P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, are for use for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient’s current health status.

See Section I.C.21. Factors influencing health status and contact with health services, Status.

f. Bacterial Sepsis of Newborn
Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

g. Stillbirth
Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother’s record.

17. Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

When a malformation/deformation/or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the malformation/deformation/or chromosomal abnormality, manifestations that are an inherent component of the anomaly
should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes Q00-Q99. For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00- Q99.

**OB-GYN Codes**

The following are diagnosis codes common to OB-GYN. Again, this guide does NOT contain every code for OB-GYN. This provides you with some insight as to how the codes you may use will look when ICD-10-CM becomes effective. Too many people are scared about ICD-10. People can become scared with things that are new. If you know how to code ICD-9, you shouldn’t have a problem coding ICD-10. I will show you the ICD-9 code for the disease and the ICD-10 code for the same disease. These are not in any specific order. Now, where did I obtain the diseases? From a superbill common to OB-GYN. Instead of looking up the ICD-9 code, I looked up the disease itself. Why? The ICD-9 code on the superbill may be wrong, deleted, or revised. The disease itself stays the same. As an example, when looking at a superbill for a practice someone placed an ICD-9 code for HIV as 042.59. There is no code 042.59. The code for HIV is 042. An employee believed that all ICD-9 codes are supposed to be 5 digit codes, so, because HIV was coded by ICD-9 as 042, they added .59 to the code. They did this with many of the codes which resulted in the superbill having many invalid codes. Some of the codes that were on the superbill were deleted several years before. The practice wondered why their claim denials increased exponentially. I do recommend that you verify the code as accurate. In construction, there is a saying, measure twice, cut once. In coding, it is verify, verify, verify!

**Diagnosis:**

**Normal delivery**  
ICD-9-CM: 650  
**ICD-10-CM:** O80 (oh 8 zero)

**Nausea with vomiting**  
ICD-9-CM: 787.01  
**ICD-10-CM:** R11.2
Supervision normal first pregnancy  
ICD-9-CM: V22.0, V22.1 or V22.2  
ICD-10-CM: Z34.80, Z34.81, Z34.82

Supervision other high-risk pregnancy  
ICD-9-CM: V23.8  
ICD-10-CM: Too many codes to list, Needs better documentation to code from O09 series codes to determine trimester.

Contraceptive surveillance unspecified  
ICD-9-CM: V25.41  
ICD-10-CM: Z30.41, Z30.42, Z30.43

Routine gynecological examination  
ICD-9-CM: V72.31  
ICD-10-CM: Z01.41

Pap smear cervix with atypical squamos cells undetermined significance (asc-us)  
ICD-9-CM: 795.01  
ICD-10-CM: R87.610, R87.611, R87.618, R87.619

Unsatisfactory smear  
ICD-9-CM: 795.08  
ICD-10-CM: R87.615, R87.625, or R85.615  
You need to document the body part involved (cervix, vagina or anus)

Depressive disorder NEC  
ICD-9-CM: 311  
ICD-10-CM: F06.31  
Can also use F41.8 for other specified anxiety disorders. Other codes are available based on documented diagnosis.

Premature menopause  
ICD-9-CM: 256.31  
ICD-10-CM: E28.31
There are many diagnosis codes used by OB-GYN, but, as you can see ICD-10 isn’t too difficult to code, and, again, the disease will stay the same. Chicken pox will stay chicken pox, chest pain will stay chest pain, but, otitis media becomes left ear otitis media, right ear otitis media or bi-lateral otitis media. Only the code changes, and the reason this is easy is because I have been trained how to code. If you can code ICD-9, you can code ICD-10. If you can’t code ICD-9, you wont be able to code ICD-10 and you wont be able to internet code. If I can do it, there is no reason why you cant do it. When ICD-10 arrives, the experts will be busy working with doctors who procrastinate and a good coder doesn’t code without looking at the medical record. Right now, internet coding is a problem. On some association or organization websites, internet coding is being highly discouraged and in many cases, the person that is internet coding may not receive an answer at all. I’ve seen some coding questions that were asked months ago and have never received an answer or the answer that was provided was 100% incorrect.

CMS publish Medicare Learning Manners SE1239 which states the following:

**ICD-9-CM codes will not be accepted for services provided on or after October 1, 2015.**

**ICD-10 codes will not be accepted for services prior to October 1, 2015.**

If you have questions related to getting ready for ICD-10, I can be reached at steveverno@hotmail.com

I wish all much success and remember my life motto: never give up and never surrender.

Steven M. Verno, CMBSI, CHCSI, CEMCS, CMSCS, CPM-MCS, CHM
References, Helpful Consultants, and Websites
(Listed in no particular order and I receive no renumeration for listing these companies/people that I trust and recommend):

Professional Association of Healthcare Coding Specialists
www.pahcs.org

Billing-Coding Advantage (BC Advantage)
www.billing-coding.com

CMS ICD-10 Myths and Facts

CMS ICD-10 Implementation Guide for small and medium practices
http://www.sccma-mcms.org/Portals/19/assets/docs/ICD10SmallandMediumPractices508.pdf

State ICD-10 Implementation Assistance Handbook

Don Self
www.donself.com

Greenbranch Publishing
www.greenbranch.com

American Health Information Management Association
www.ahima.org

Centers for Medicare and Medicaid Services ICD-10
https://www.cms.gov/ICD10/
World Health Organization ICD-10
http://apps.who.int/classifications/apps/icd/icd10online/

American Medical Association ICD-10

National Uniform Claim Commission
http://www.nucc.org

Turbocoder
www.turbocoder.net