



CompuGroup™
Medical

What's New in

CGM® webPRACTICE™ v7.4.4

Final Release Notes

Updated Document January, 29, 2014

Version Release Date: December 19, 2013

CGMwebPRACTICE™

Fully Web-Based Practice Management Suite



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INTRODUCTION

This document provides an overview of new features, resolutions and enhancements available in the release of CGM webPractice v7.4.4. Each section defines the specific feature and/or enhancement associated with the new CGM webPractice release, as well as any resolved issues.

Additional release notes that were not available at the time of the release of 7.4.4 have been added in the “Additional 7.4.4 Release Notes” section starting on page 35.

NEW FEATURES AND ENHANCEMENTS

This section is not meant to be cumulative and only contains information associated with the CGM webPractice v.7.4.4 release.

Note: You will need to complete the *****Action Required***** items (where applicable) to make sure your system functions properly with this updated version.

As with all service packs and updates, for all new menu functionality, you will need to identify which users you want to have access to the new menu functions. Then, you must activate the new menus using the **Model User Menus** function located on the *System, User Management* menu. You must also set the security level that you want on the new menus using the **Change Function Security** function located on the *System, User Management, Function Security Menu*.

Summary of Action Required Items

Page #	Function	Action
21	CGM webPractice Integration Options	You need to indicate which claim format to use when printing claims for insurance carriers.
22	Paper Claim Editor	You need to manually enter any existing custom Profile Rules for the new CMS-1500 (02/12) form.
22	Paper Claim Alignment	You need to manually enter any existing custom Profile Rules for the new CMS-1500 (02/12) form.
23	Column Selectable Fields	If you want the ICD-10 / Other column to display in <i>Unposted Procedures</i> , you need to add a Sequence number for the field.
24	Maintain Insurance Carriers	Select the Use CMS-1550 (02/12) check box for the applicable insurance Carriers.
24	Maintain Insurance Carriers	Contact Customer Service to request to have a pass-thru done to select the applicable insurance carriers/plan codes.
25	Load ICD-10-CM Codes	You need to load the ICD-10 code set (<i>included in 7.4.4</i>) into the <i>Diagnosis Code Table</i> prior to posting 'practice' claims.
27	Import Fee Schedules	Import the updated files if applicable.
27	Load the AMA HCPCS Codes	Load the updated files if applicable.

CGM webPractice Enhancements

CGM webPractice Enhancements

System wide enhancements have been made to accommodate the new CMS-1500 (02/12) form. Any items requiring action on your part have been itemized in the applicable sections of these release notes and flagged as *****Action Required*****.

The National Uniform Claim Committee ([NUCC](#)) and The Centers for Medicare and Medicaid Services ([CMS](#)) are adhering to the following timeline for the transition to accepting the new form:

January 6, 2014: Payers begin receiving and processing paper claims submitted on the revised 1500 Claim Form (version 02/12).

January 6 through March 31, 2014: Dual use period during which payers continue to receive and process paper claims submitted on the old 1500 Claim Form (version 08/05).

April 1, 2014: Payers receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12).

CGM webPractice Enhancements

ICD-10 Phase I enhancements have been made to accommodate the new ICD-10 diagnosis codes. Any items requiring action on your part have been itemized in the applicable sections of these release notes and flagged as *****Action Required*****.

Notes:

- **ICD-10 Testing:** Some insurance carriers will be conducting ICD-10 testing and some will not. For those conducting ICD-10 testing, the methods used (spreadsheet, portal, electronic claim file) and timeframes vary greatly. If you have been contacted by a payer to conduct ICD-10 testing, you can open an **ICD-10 Testing** support call for assistance. Customer Service will gather specific details to be evaluated by the CGM webPractice and EMEDIX development teams to assess the testing possibilities. Since ICD-10 testing is not mandated and testing methods are not standardized, each request will have to be evaluated separately.
- **ICD-10 Phase II**, to be released early next year, will contain additional ICD-10 enhancements, such as:
 - The ability to use the **Check Codes** function with ICD-10 codes and the webCoder website.
 - The ability to use ICD-10 codes in webMobile.

Later phases, to be released in the 2nd and 3rd quarter of next year, will ensure full preparedness and complete ICD-10 claim functionality well in advance of the October 1, 2014 deadline.

CGM webPractice Enhancements (cont.)

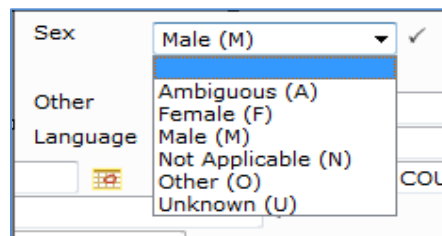
CGM webPractice Compatibility

Compatibility testing has been successfully completed for running CGM webPractice in a Windows 8 and Internet Explorer 10 environment. The only requirement is that you must use **Compatibility View** in Internet Explorer.

CGM webPractice Enhancements

To assist in meeting Meaningful Use Stage 2 requirements for EHRs, the options for selecting the **Patient's Sex** have been expanded in every function that contains a **Patient's Sex** field. You now have the following list to select from:

- Male (M)
- Female (F)
- Ambiguous (A)
- Not Applicable (N)
- Other (O)
- Unknown (U)

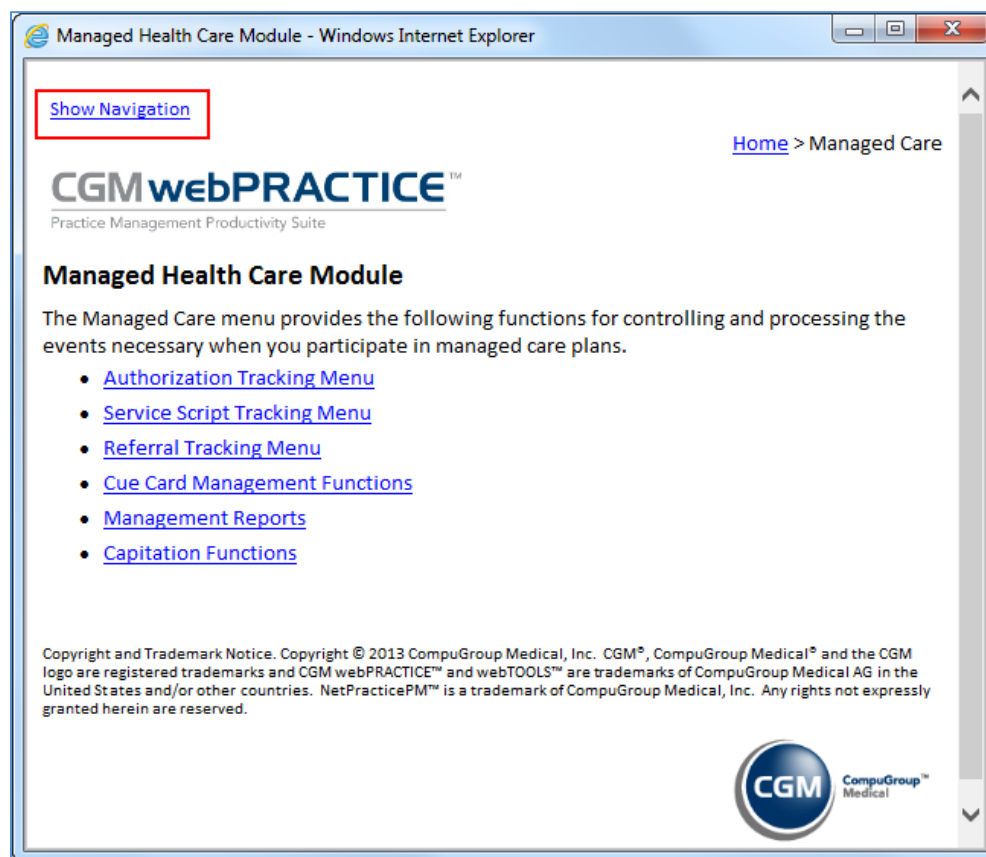


User Desktop

Help - Desktop Tools

Online Help has been imported into a new platform and updating the content will no longer be dependent on the distribution of software releases. This will allow us to frequently update Help to provide you with more accurate and up-to-date information. The new Help platform also includes a robust Search function and additional new features such as a Glossary, Index, and Tutorials which will be provided in the coming months.

When you click the **Help** Desktop Tool, the Help window will appear and display the applicable content for the function you have currently accessed within CGM webPractice.

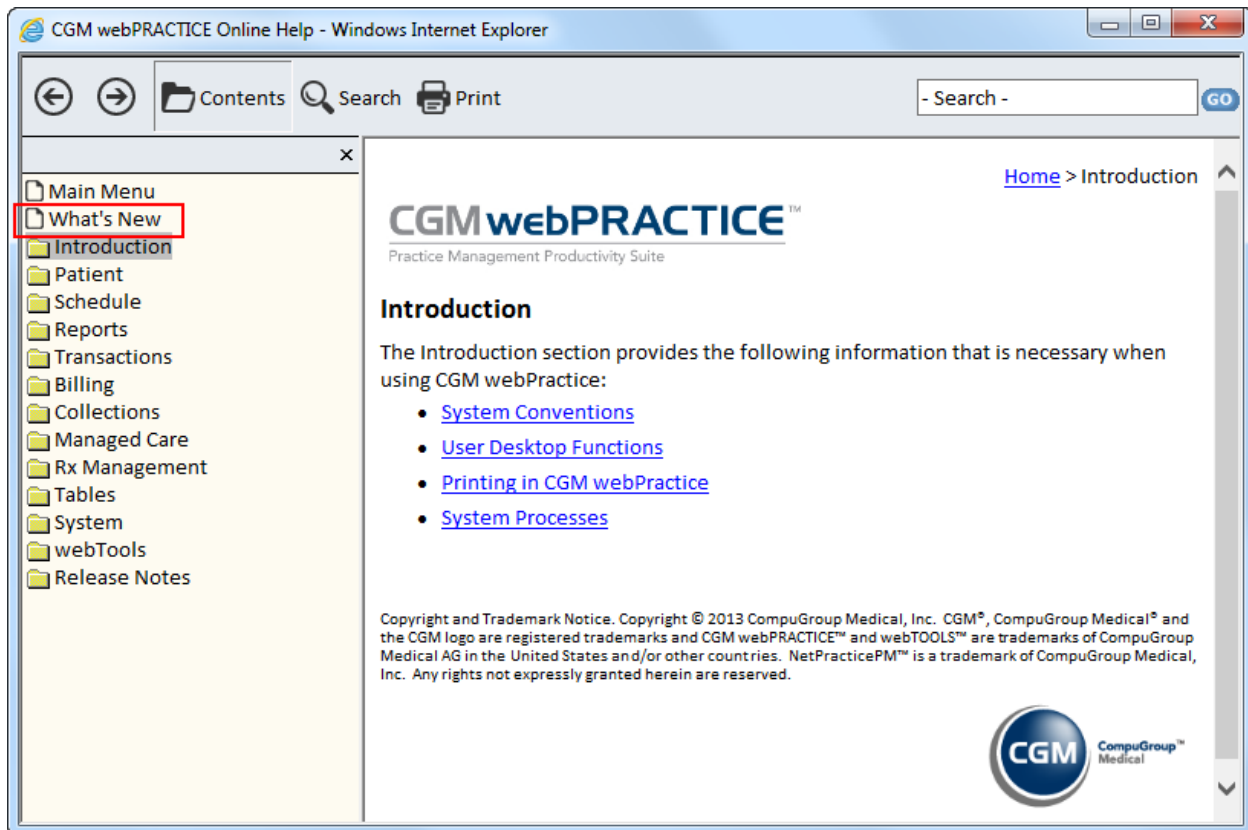


You can click the **Show Navigation** link in the upper-left corner to display the Table of Contents and other Help functions.

User Desktop (cont.)

Help - Desktop Tools (cont.)

A “What’s New” page has been added that will provide an ongoing list of content updates that have been completed and it will also include a list of the functions that are scheduled to be updated soon.



****Note:** The new Help system is expected to be ‘live’ on Dec. 23, 2013.

Billing

Print Patient Statements and Print History Statements

If you have the **Create Ins on Locked Batches Only** check box selected in the *CGM webPractice Default Values* function, a new message has been added that will notify you when there are procedures in an unlocked batch that insurance has not been created for yet. Since charges are stored as 'patient balances' until insurance has been created, this message will appear when you click **Save**, so you can prevent sending statements to patients for balances that have not been filed to insurance yet.

Create Insurance File (*Insurance Billing Functions*)

Enhancements have been made in preparation of generating and splitting claims for encounters containing Dates of Service that span the **ICD-10 Activation** date for an insurance carrier. At least two claims will generate; one for the ICD-9 codes and one for the ICD-10 codes. If any Billing Profile Rules have been set up they will also be taken into account when splitting the claim in addition to the standard claim splitting rules already in use.

Note: The standard claim splitting rules can include the following:

- Professional vs. institutional charges
- ICN number
- Splitting procedures to paper if the claim is electronic but a CPT is set to Print to Paper or contains a PP modifier
- Medicare vs. DMERC for home supply CPT codes
- Paper professional claims will split on 6 charges per claim and 4 diagnosis codes if the form is CMS-1500 (08/05)
- Accept Assignment
- Dates of Service (DOS)
- Immunization Code
- Insurance Carrier if the policy Effective Dates are different in the middle of a range of DOS

The claim splitting functionality ties directly into the new ICD-10 Preview Encounter Action and determines how many 'practice' claims will be generated for previewing. For additional information on viewing 'practice' claims, see the **History - ICD-10 Codes** entry under the *Patient* section of these release notes.

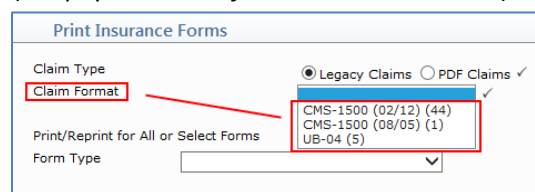
Note: The rules governing how a claim should be split were obtained from *The Centers for Medicare & Medicaid Services (CMS) - Medicare Learning Network Matters Articles (MLN) MM7492 and MLN SE1325*. A summary of these rules has been provided in Appendix A of these release notes.

Billing (cont.)

Print Insurance Forms, Reprint Insurance Forms, Print Delinquent Insurance Forms, and Reprint Delinquent Insurance Forms (Insurance Billing Functions)

These functions have been updated with the following changes to accommodate printing insurance claims on the new CMS-1500 (02/12) form:

- The **Print for which type of Claim** field has been renamed to **Claim Type**.
- A new **Claim Format** list has been added so you can select the applicable claim format you want to print. The list contains options for:
 - CMS-1500 (02/12) (44)– *(the new CMS form)*
 - CMS-1500 (08/05) (1) – *(the old CMS-1500 form)*
 - UB-04 (5) – *(the paper version for institutional claims)*



- The UB92 (5) option has been removed from the **Form Type** list. You will need to select UB-04 from the **Claim Format** list instead.

For additional information on the updates done for the new CMS-1500 (02/12) form, see the **Maintain Insurance Carriers** entry in the *Tables* section of these release notes.

Print Exception Report (Insurance Billing Functions, Electronic Claims)

A new electronic claims exception has been added for “Anesthesia procedures cannot span the ICD-10 effective date for this carrier” in case an anesthesia claim contains a **Through** Attachment that spans the **ICD-10 Activation Date** for an insurance carrier. If you receive this exception message, you should edit the encounter, delete the **Through** Attachment and split the charges into two separate claims; one for each date with the appropriate ICD codes.

Print Insurance Forms (Insurance Billing Functions)

During the transition period of payers accepting ICD-10 codes, there may be situations that require you to submit ICD-10 codes on the old version of the paper claim forms. The functions for printing the CMS-1500 (08/05) and the UB-04 paper claim forms have been updated accordingly. The claim will print either ICD-9 or ICD-10 codes, depending on the **ICD-10 Activation** date entered for the insurance carrier code in the *Insurance Carrier Table*.

Insurance Filing Report (Insurance Billing Functions) and Delinquent Filing Report (Insurance Billing Functions, Delinquent Insurance Menu)

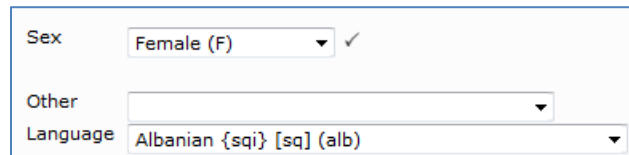
The **Print for which type of Claim** field has been renamed **Claim Type** to be consistent with the other Billing functions that were updated for the new CMS-1500 (02/12) form.

Patient

Change Patient Data

Patient Name and Address Information

To assist in meeting Meaningful Use Stage 2 requirements for EHRs, the ISO 639-1 codes have been added to the Language list. When the ISO 639-1 code exists for a language, it will be listed in brackets [], after the ISO 639-2 Terminology {T} code (if it exists) and then the ISO 639-2 Bibliographic (B) code (which always exists). For additional information, see the **Maintain Language Codes** section in the *Tables* section of these release notes.



Patient Name and Address Information

To assist in meeting Meaningful Use Stage 2 requirements, the Ethnicity and Race Code Tables have been modified as shown in the table below.

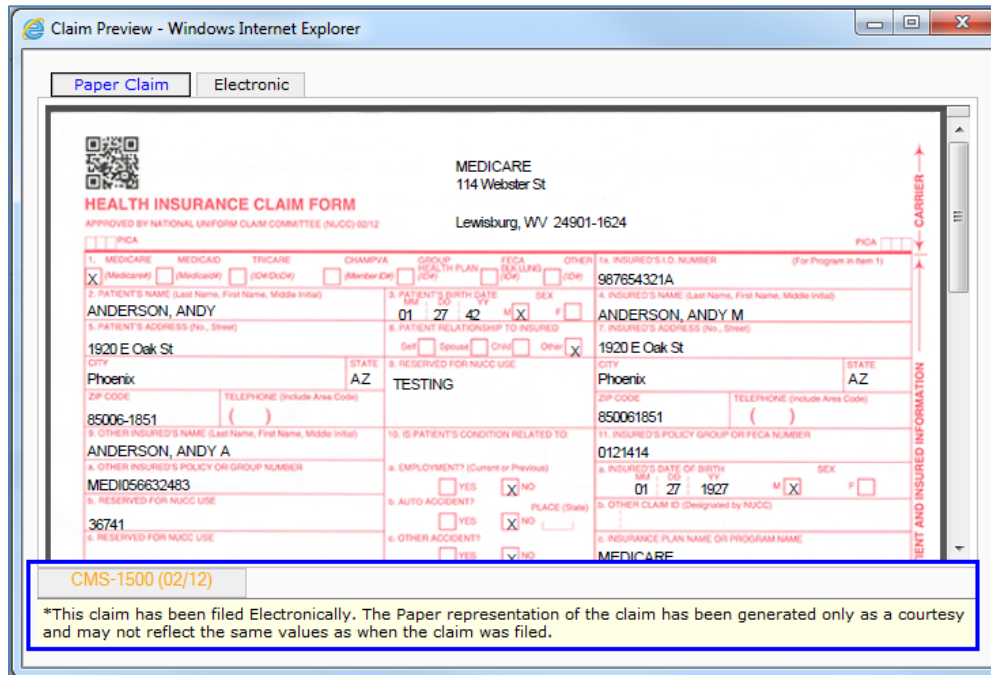


Table Name	Previous Code	Updated Code
Ethnicity	Patient Declined or Unavailable (0)	Declined to Specify (0)
Race	Unreported/Refused to Report (0)	Declined to Specify (0)
Race	More than one race (8)	<i>Code deleted from table</i>

Patient (cont.)

History – Encounter View

The paper claim preview function has been updated to accommodate the new CMS-1500 (02/12) claim form. Additionally, the paper insurance form names have been added to the bottom of the claim preview screen to indicate which form the claim was filed on, along with a new informational message stating how the claim was originally filed.



Claim Preview - Windows Internet Explorer

Paper Claim Electronic

MEDICARE
114 Webster St
Lewisburg, WV 24901-1624

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0212

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA (EX-LIFE) OTHER
 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ANDERSON, ANDY
3. PATIENT'S BIRTH DATE
01 27 42
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ANDERSON, ANDY M
5. PATIENT'S ADDRESS (No., Street)
1920 E Oak St
6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other
 7. INSURED'S ADDRESS (No., Street)
1920 E Oak St
8. RESERVED FOR NUCC USE
TESTING
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
ANDERSON, ANDY A
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO
 c. OTHER ACCIDENT? YES NO
 11. INSURED'S POLICY GROUP OR FECA NUMBER
0121414
 12. INSURED'S DATE OF BIRTH
01 27 1927
 13. OTHER CLAIM ID (Designated by NUCC)
36741
 14. INSURANCE PLAN NAME OR PROGRAM NAME
MEDICARE

CARRIER

SENT AND INSURED INFORMATION

CMS-1500 (02/12)

*This claim has been filed Electronically. The Paper representation of the claim has been generated only as a courtesy and may not reflect the same values as when the claim was filed.

For additional information on the new CMS-1500 (02/12) claim form, see the entries under the *System* and *Tables* sections of these release notes.

Note: The paper claim preview function is only applicable if the database has been set up to print PDF paper insurance claims.

Patient (cont.)

History – ICD-10 Codes - *New Functionality*

Several enhancements have been made to accommodate the ICD-10 codes. The Encounter view screen will display both ICD-9 codes and ICD-10 codes in the top section of each encounter.

Transaction History
System Manager
Eastside Medical (1)

Patient:
23936 - ANDERSON, ANDY **
555 MAIN STREET
Phoenix, AZ 85006-1851
602-555-5555
PATIENT HARD OF HEARING

A - All Cases

Encounter

Date of Service

From Thru Go

Actions...

Encounter 6595 - 12/16/2013

Case 0 - Not applicable Status Open

Billing Group MED

ICD-9 Diagnosis Code(s): ICD-10 Diagnosis Code(s):

249.0 - SECONDARY DM WO COMPL E08 - Diabetes mellitus due to underlying condition
M48.40 - Fatigue fracture of vertebra, site unspecified

MED AARP Authorization

Service Date	Code	Description	\$ Charge	\$ Ins	\$ Pat Img
12/16/2013	99214	OFFICE/OUTPATIENT VISIT EST	\$142.00	\$142.00	\$0.00
12/16/2013	36415	ROUTINE VENIPUNCTURE	\$13.00	\$13.00	\$0.00
Totals:			\$155.00	\$155.00	\$0.00

Last Saved 12/16/2013 10:03AM by MGR

Note: If ICD-10 codes were not entered or stored on the encounter during procedure entry, the heading for the ICD-10 codes will be suppressed from displaying.

The Legacy Transaction History Views will display the ICD-10 codes when the procedure detail has been expanded. The diagnosis codes that are tied to the charge will display (determined by the diagnosis pointers entered when the procedure was posted), as well as any encounter level diagnosis codes; if there were any additional codes that were not attached to the procedure line items.

Transaction History
System Manager
Eastside Medical (1)

Patient:
23936 - ANDERSON, ANDY **
555 MAIN STREET
Phoenix, AZ 85006-1851
602-555-5555
PATIENT HARD OF HEARING

A - All Cases

Insurance w/Doctor

Date of Service

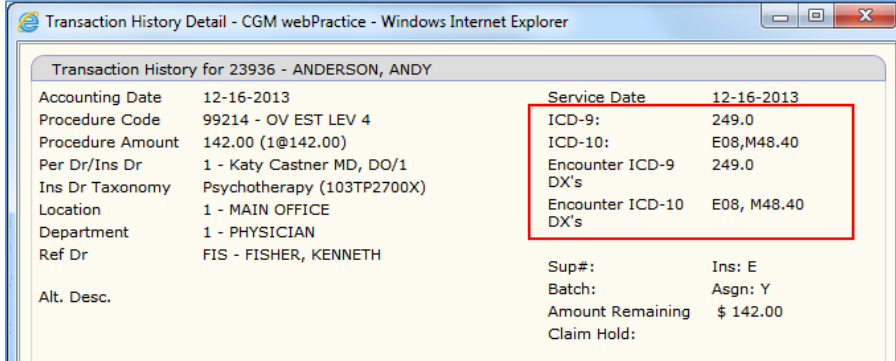
From Thru Actions:

Acc/Date	Ser/Date	Case	Code	Description	Org/Amt	Lc	Dr	Ins/Bal	Pat/Bal	I	Img	Act
12-16-13	12-16-13	0	F 99214	OV EST LEV 4	142.00	1	1	142.00		EY		<input type="checkbox"/>
ICD-9 Diagnosis:				249.0 - SECONDARY DM WO COMPL								
ICD-9 Encounter DX's:				249.0								
ICD-10 Diagnosis:				E08 - Diabetes mellitus due to underlying condition M48.40 - Fatigue fracture of vertebra, site unspecified								
ICD-10 Encounter DX's:				E08, M48.40								

Patient (cont.)

History – ICD-10 Codes (cont.)

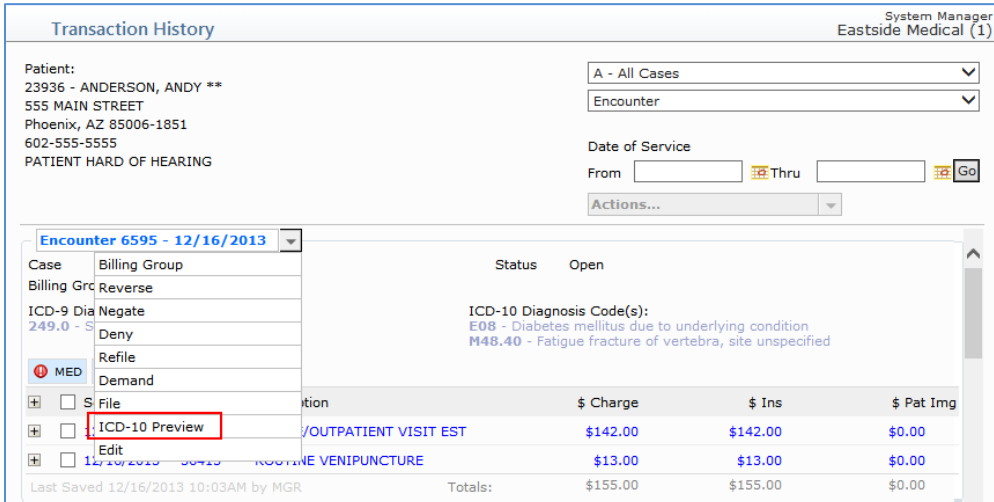
The **Transaction History Detail** screen now displays ICD-10 codes and the ICD-9 code display has been modified. The diagnosis codes that are tied to the charge will display first (determined by the diagnosis pointers entered when the procedure was posted), and then any encounter level diagnosis codes will display.



Transaction History for 23936 - ANDERSON, ANDY		Service Date 12-16-2013	
Accounting Date	12-16-2013	ICD-9:	249.0
Procedure Code	99214 - OV EST LEV 4	ICD-10:	E08,M48.40
Procedure Amount	142.00 (1@142.00)	Encounter ICD-9	249.0
Per Dr/Ins Dr	1 - Katy Castner MD, DO/1	DX's	
Ins Dr Taxonomy	Psychotherapy (103TP2700X)	Encounter ICD-10	E08, M48.40
Location	1 - MAIN OFFICE	DX's	
Department	1 - PHYSICIAN		
Ref Dr	FIS - FISHER, KENNETH	Sup#:	Ins: E
Alt. Desc.		Batch:	Asgn: Y
		Amount Remaining	\$ 142.00
		Claim Hold:	

History - ICD-10 Codes - *New Functionality*

A new **ICD-10 Preview** Encounter Action will be available in Encounter View to preview 'practice' claims containing ICD-10 codes, if you entered ICD-10 diagnosis codes when posting Encounters and *have created insurance* for the encounters. If the encounters do not contain any ICD-10 diagnosis codes this action will be inactive.

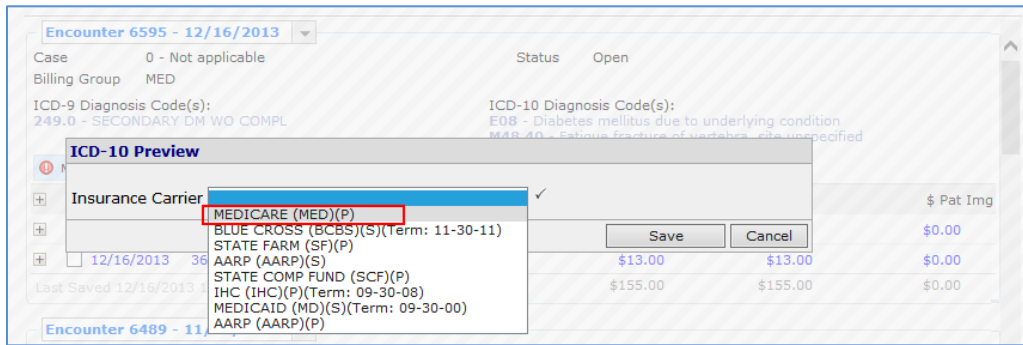


Transaction History		System Manager Eastside Medical (1)	
Patient: 23936 - ANDERSON, ANDY ** 555 MAIN STREET Phoenix, AZ 85006-1851 602-555-5555 PATIENT HARD OF HEARING		A - All Cases Encounter Date of Service From [] Thru [] Go Actions...	
Encounter 6595 - 12/16/2013		Status Open	
Case	Billing Group	ICD-10 Diagnosis Code(s): E08 - Diabetes mellitus due to underlying condition M48.40 - Fatigue fracture of vertebra, site unspecified	
Billing Gr	Reverse		
ICD-9 Dia	Negate		
249.0 - S	Deny		
	Refile		
	Demand		
	File		
	ICD-10 Preview		
	Edit		
	12/16/2013 09:15 ROUTINE VENIPUNCTURE	\$ Charge	\$ Ins
		\$142.00	\$142.00
		\$13.00	\$13.00
		\$0.00	\$0.00
Last Saved 12/16/2013 10:03AM by MGR		Totals:	\$155.00 \$155.00 \$0.00

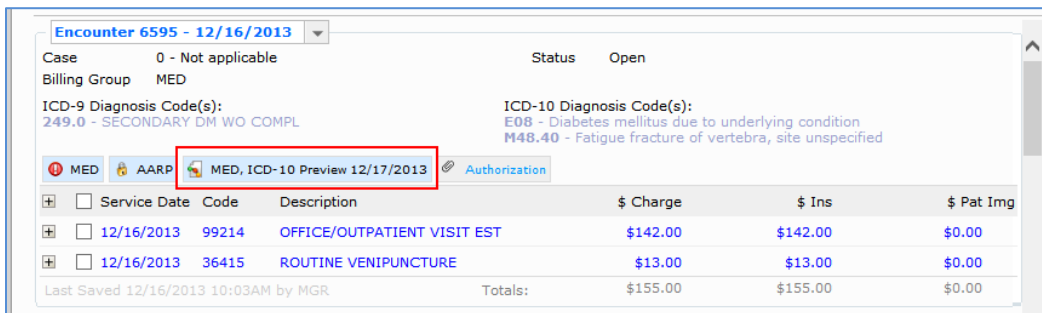
Patient (cont.)

History - ICD-10 Codes (cont.)

After selecting the **ICD-10 Preview** Encounter Action, select the insurance carrier to create the 'preview claim' and click **Save**.



You can now view the practice claim using the ICD-10 Preview tab in the encounter.



The ICD-10 preview claim is strictly a 'practice claim' and will *not* generate an actual insurance claim, will *not* be sent to the insurance carrier, and an entry will *not* be added to the Insurance Ledger. It is for preview and practice purposes only.

Patient (cont.)

History - ICD-10 Codes (cont.)

Claim Preview Windows Internet Explorer

Paper Claim | Electronic

8. OTHER INSURED'S POLICY OR GROUP NUMBER
MEDI06632483

9. RESERVED FOR NUCC USE
36741

10. INSURANCE PLAN NAME OR PROGRAM NAME
PHILADELPHIA, PA 19187-0216

11. EMPLOYMENT? (Current or Previous)
 YES NO

12. AUTO ACCIDENT?
 YES NO

13. INSURED'S DATE OF BIRTH
01 27 1927 M F

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)
QUAL: _____

15. OTHER DATE
QUAL: _____

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM: _____ TO: _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
KENNETH M FISHER MD

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM: _____ TO: _____

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Please A-C to service line below (24E) ICD-10: 10

From	To	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	DIAGNOSIS POINTER	\$ CHARGES	S	R	L	J					
MM	DD	YY	MM	DD	YY		SKN	FRY	INR	REN					
12	16	13	12	16	13	11	99214			A,B	142.00	1		NP	1770805590
12	16	13	12	16	13	11	36415			A	13.00	1		NP	1770805590

CMS-1500 (02/12)

Note:

- Only the procedures that contain ICD-10 codes will display in the ICD-10 Preview claim.
- It is possible for more than one preview claim to be generated if the claim is split and multiple ICD-10 Preview tabs may display.

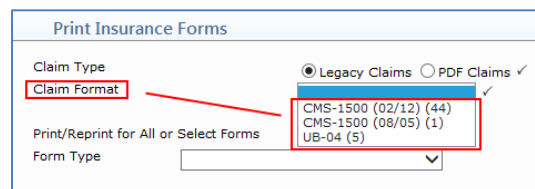
For additional information on the ICD-10 codes, see the entries under the *Transactions* and *Tables* sections of these release notes.

Collections

Print Insurance Forms and Reprint Insurance Forms (*Insurance Collections*)

These functions have been updated with the following changes to accommodate the new CMS-1500 (02/12) form:

- The **Print for which type of Claim** field has been renamed to **Claim Type**.
- A new **Claim Format** list has been added so you can select the applicable claim format you want to print. The list contains options for:
 - CMS-1500 (02/12) (44) – *(the new CMS form)*
 - CMS-1500 (08/05) (1) – *(the old CMS-1500 form)*
 - UB-04 (5) – *(the paper version for institutional claims)*



- The UB92 (5) option has been removed from the **Form Type** list. You will need to select UB-04 from the Claim Format list instead.

Reports

Compile UDS Reports and Print UDS Reports (UDS Reports)

The UDS Audit Report has been enhanced to track procedures that were not counted as Encounters if 'M' or 'F' is not selected for a patient's Sex. These procedures will be included in the **Non Encounters** column under the applicable **Category**.

AUDIT REPORT			
Oct 30, 2013			
Eastside Medical			
Reporting Period: October 1, 2013 through October 22, 2013			
Category	Encounters	Non Encounters	Secondary Procedures
None	0	14	0
Medical Care	34	10	42
Dental	0	0	0
Mental	0	0	0
Substance Abuse	0	0	0
Other Professional	0	0	0
Enabling	0	0	0

[Click this link to view detailed information for this report.](#)

Any of the numbers listed for the procedures in each column are links which you can click to view detailed information for the report.

AUDIT REPORT								
Oct 30, 2013								
Line: Medical Care								
Column: Non Encounters								
Eastside Medical								
Reporting Period: October 1, 2013 through October 22, 2013								
Account	Name	CPT	Diag	DOS	Amount	Dr	Loc	Reason
26216	Radley, Boo	99214	100.89	10-21-2013	142.00	1	1	Patient sex is undetermined
26216	Radley, Boo	99214	100.89	10-15-2013	142.00	1	1	Patient sex is undetermined
26216	Radley, Boo	36415	100.89	10-15-2013	13.00	1	1	Patient sex is undetermined
26217	Finch, Jem	10080	100.89	10-13-2013	150.00	1	1	Patient sex is undetermined
26217	Finch, Jem	99214	100.89	10-13-2013	142.00	1	1	Patient sex is undetermined
26218	Ewell, Bob	99214	100.89	10-12-2013	142.00	1	1	Patient sex is undetermined
26218	Ewell, Bob	36415	100.89	10-12-2013	13.00	1	1	Patient sex is undetermined
26219	Harris, Dill	10080	100.81	10-14-2013	125.00	1	1	Patient sex is undetermined
26219	Harris, Dill	99214	100.81	10-14-2013	142.00	1	1	Patient sex is undetermined
26219	Harris, Dill	36415	100.81	10-14-2013	13.00	1	1	Patient sex is undetermined

Compile UDS Reports and Print UDS Reports (UDS Reports)

The UDS report 3A – *Users by Age and Gender* has been updated to assist in meeting Meaningful Use Stage 2 requirements for EHRs. The only patient accounts that will be included in the report will have **Male** or **Female** selected for the **Patient's Sex** field.

Reports (cont.)

Medicare PQRS Report to Excel (*Insurance Related Reports*) – ***New Functionality***

This report has been added to assist providers who are reporting their PQRS (Physician Quality Reporting System) data via a reporting registry. This report was designed to print to Excel so you can save it to any folder location and then send it to a PQRS registry.

Note: The 1.5% penalty on Medicare payments will occur in 2015 if you don't report for 2013. Registry reporting is just one of four acceptable PQRS reporting methods (claims, registry reporting, EHR incentive reporting, Group Practice Reporting). You can view detailed information about PQRS directly on the [CMS PQRS website](#).

The report will contain the following fields:

- TIN – Tax ID Number
- NPI – National Provider Identifier (NPI) stored for the insurance doctor code stored on the encounter
- HIC - Health Insurance Claim number (Policy # stored for the insurance policy in webPractice)
- First_Name – Patient's first name
- Last_Name – Patient's last name
- Pt_MRN – Patient's Medical Record Number (account number)
- Pt_Gender – The option selected for the Patient's Sex field
- Pt_DOB – Patient's Date of Birth
- Visit_Date – Service Date of the charge
- Prim_Insurance – Primary insurance carrier name
- Sec_Insurance – Secondary insurance carrier name
- ICD-9 – The ICD-9 diagnosis code stored on the charge. If a single charge has multiple diagnosis codes stored on it, a separate line of data will print for each diagnosis codes, up to the limit of four diagnosis codes.
- ICD-10 – This field will not be in use until the ICD-10 codes become effective
- CPT – The procedure code for the charge
- Modifiers – Any modifiers posted for the charge
- POS – The Medicare Place of Service code stored in the Location Code table in the Equivalent field assigned to the Medicare carrier.

The report has been designed to search 90 days before and after the date range you select to make sure the applicable service dates are captured, since charges are stored in webPractice by Accounting Date.

Note: This report will ONLY include charges for primary or secondary insurance carriers in effect at the time of the service date and have the **Insurance Form Type** set to 'C' in the *Insurance Carrier Table*.

Reports (cont.)

Compile UDS Reports and Print UDS Reports (UDS Reports)

The UDS Reports have been updated to meet the new Calendar Year 2013 reporting standards for Reporting Year 2014. This includes the Zip Code report which was re-designed to sort the patient counts by the patient's insurance coverage.

ZIP CODE REPORT Eastside Medical Reporting Period: October 1, 2013 through November 30, 2013				
Zip Code (a)	None/Uninsured (b)	Medicaid / CHIP / Other Public (c)	Medicare (d)	Private Insurance (e)
Other Zip Codes	3	0	4	18
Unknown Residence	0	1	1	1
Column Totals	3	1	5	19
Grand Total	28			

[Click this link to view detailed information for this report.](#)

Note: It is possible for a patient to fall under more than one insurance category (Medicare, Medicaid, Private, None) during the reporting period. To prevent the patient from being counted twice, the insurance category from the 'Last' encounter posted on the patient's account during the reporting period will be used.

Schedule

Enter Patient Appointments

An issue has been resolved that prevented a patient's future appointments from printing when using **Print** in the Action column while on the patient's appointment screen.

System

CGM webPractice Integration Options – (Database Maintenance Menu) ***Action Required***

To accommodate the new CMS-1500 (02/12) functionality there are now separate sections for Legacy and PDF claims so you can indicate which claim format to use when printing claims for insurance carriers.

Legacy Claims:

Use CMS-1500 (08/05)

Use UB-04

PDF Claims:

Enable Paper Claim Editor and Alignment Functions (PDF)

Use CMS-1500 (02/12)

For Legacy claims, the **Use NPI CMS Form** check box was renamed **Use CMS-1500 (08/05)** and the **Use NPI UB Form** check box was renamed **Use UB-04**. The PDF Claims section contains the **Enable Paper Claim Editor and Alignment Functions (PDF)** check box and the new **Use CMS-1500 (02/12)** check box.

The **Use CMS-1500 (02/12)** check box controls which claim format to use *at a system level*. If you select this check box it will generate claims using the PDF **CMS-1500 (02/12)** form for *ALL* insurance carriers in the insurance carrier table regardless of the individual setting within each insurance carrier code. After this field has been selected, the **Use CMS-1500 (08/05)** check box in the Legacy Claims section will be inactivated for future use and the new **Use CMS-1500 (02/12)** check box in the *Maintain Insurance Carriers* function will be inactivated. Be aware that when these fields are inactivated, the current settings for those fields will remain as such (either selected or cleared). Even though this may be visually confusing, it must be handled this way to allow for clients that use 'State Forms' and also for the transition period when you may have Legacy claims waiting in the print file although you have elected to switch to the new form.

Note:

- You also have the option to generate claims using the new form for select insurance carriers if you prefer. For additional information, see the *Maintain Insurances Carriers* entry under the Tables section of these release notes.
- If the **Enable Paper Claim Editor and Alignment Functions (PDF)** check box is selected, the **Use UB-04** field will be inactivated.

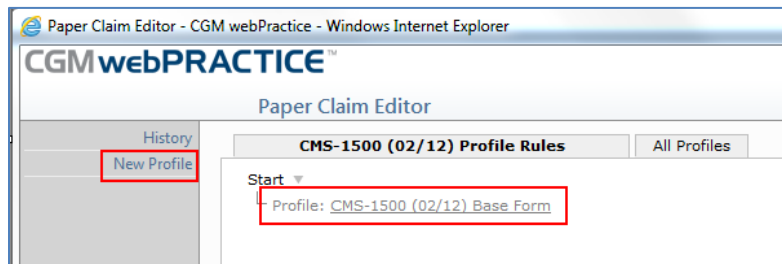
System (cont.)

Paper Claim Editor - ***Action Required***

A new claim form has been added for the new CMS-1500 (02/12) form. The existing form has been renamed CMS-1500 (08/05) and the Institutional claim has been renamed UB-04. The new CMS-1500 (02/12) form will not inherit any of the existing custom Profile Rules currently attached to the CMS-1500 (08/05) form so if you have any existing custom Profile Rules that would apply to the new form; you will need to enter them manually.

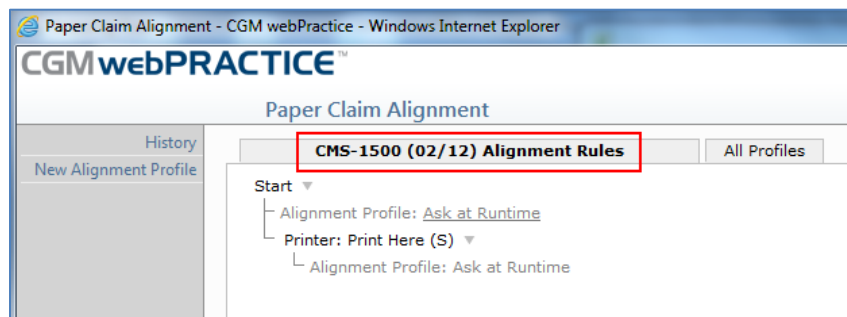
When you access this function and select the new CMS-1500 (02/12) form, it will only contain the Profile Rules for the **CMS-1500 (02/12) Base Form**. For a list of the box changes made based on the documentation from *NUCC.org*, see Appendix B of this release note document.

You can create a new Profile by clicking **New Profile** in the Action Column.



Paper Claim Alignment - ***Action Required***

A new claim form has been added for the new CMS-1500 (02/12) form. The existing form has been renamed CMS-1500 (08/05) and the Institutional claim has been renamed UB-04. The new CMS-1500 (02/12) form will not inherit any of the existing custom Alignment Profile rules currently attached to the CMS-1500 (08/05) form so if you have any existing custom Alignment Profile Rules that would apply to the new form; you will need to enter them manually.



System (cont.)

Maintain Users (User Management)

The **Update Help Notes** check box has been removed. With the implementation of the new Online Help system, **Help** will no longer be able to store 'client-specific' notes. Any clients that did store 'notes' in **Help** will be notified by certified letter prior to the release of 7.4.4.

Column Selectable Fields ***Action Required*** (for existing User Codes)

An **ICD-10 / Other** field has been added to the **Unposted Procedures** field options so you can indicate if you want the codes to display in the *Unposted Procedures* and *Pre-Treatment* functions by adding a column sequence number.

Column Selectable Fields	
	Unposted Procedures
Column Name	
Checkbox	
Sta	
Source	
Account	
Patient Name	
Superbill	
ICD-9/Other	
ICD-10/Other	

Note: The ICD-10 / Other column will automatically display in the *Unposted Procedures* and *Pre-Treatment* functions for any new **User Code** created after the 7.4.4 release has been installed. For any existing **User Codes**, you will need to manually add a **Sequence** number for the **ICD-10 / Other** field, to indicate which column position you want the codes to display.

webCoder Integration *webCoder clients only* *New Functionality*

A new **Providers** function has been added to the Action Column that provides a **Select All/Clear** toggle button so you can quickly select or clear every Doctor code when setting up the integration.

Tables

Maintain Insurance Carriers (*Insurance Carrier Table*) - ***Action Required***

A new **Use CMS-1500 (02/12)** field has been added. This field will only be available if the database has been set up to print PDF paper insurance claims. When you select this field, all claims for the selected insurance carrier will be generated in this format (this would include any claims that were refiled or created and are already in the current insurance file). For additional information, see the *CGM webPractice Integration Options* entry under the System section of these release notes.

Maintain Insurance Carriers (*Insurance Carrier Table*) - *New Functionality* ***Action Required***

A new utility has been created for Customer Service so they can assist you in setting up your insurance carriers to use the new form, thereby eliminating much of the manual work. This utility was designed for the following situations:

- When you have a few specific insurance carriers that do **not** accept the **CMS-1500 (02/12)** form, the utility can be run to select the **Use CMS-1500 (02/12)** check box for All carriers in the Insurance Carrier Table and then you can clear the check box for those few carriers that do not accept the form.
- When you have carriers that are tied to a specified plan code(s) that will accept the **CMS-1500 (02-12)** form, this utility can be run to select the **Use CMS-1500 (02/12)** check box for those specific carriers with the specified plan code(s).

Maintain Insurance Carriers (*Insurance Carrier Table*)

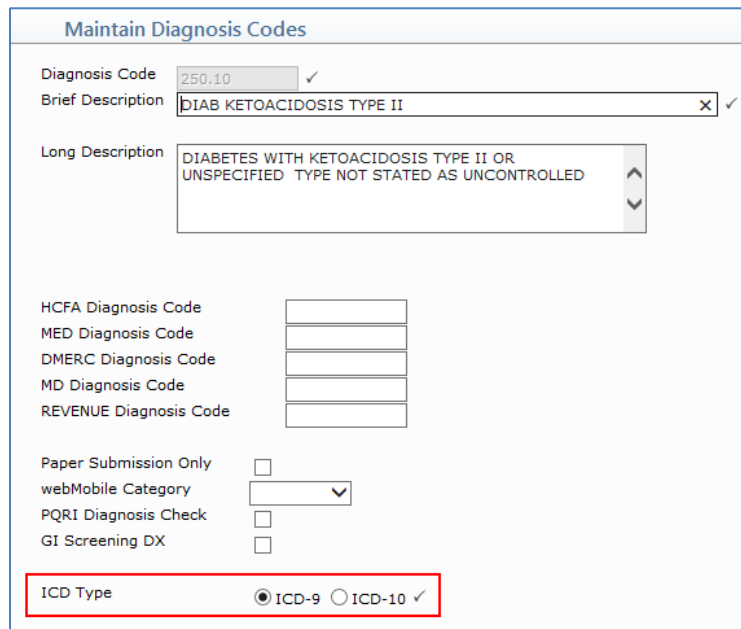
A new **ICD-10 Activation** field has been added to hold the effective date when the carrier will require claims to be submitted with ICD-10 diagnosis codes. This field will be defaulted to the effective date mandated by CMS which is 10/1/2014 for all existing insurance carriers and cannot be edited at this time.


Eligibility Verification Frequency	<input type="text"/>	<input type="checkbox"/>	PCCM Program	<input type="checkbox"/>
Verify when Payer is Secondary	<input type="checkbox"/>		Public Insurance	<input type="checkbox"/>
Managed Care Plan	<input type="checkbox"/>			
Typology Code	<input type="text"/>			
5010 Format	<input type="text"/>			
ICD-10 Activation	<input type="text" value="10-01-2014"/>		Use CMS-1500 (02/12)	<input type="checkbox"/>

Tables (cont.)

Maintain Diagnosis Codes (*Diagnosis Code Table*)

A new **ICD Type** field has been added to indicate if the diagnosis code is an ICD-9 or ICD-10 code. The **ICD Type** field will automatically be set to ICD-9 for all of the existing codes in the table when the 7.4.4 release is installed. When the ICD-10 codes are loaded into the table using the *Load ICD-10-CM Codes* function, the **ICD Type** field will be set to ICD-10 automatically.



Note: For the first phase of the ICD-10 updates, you will only be able to search and select ICD-10 codes in *Procedure Entry* and the *Maintain Diagnosis Codes* functions. In every other function that provides the diagnosis code search capability, the **Search** icon  will only search through the ICD-9 codes currently stored in the table even if the new ICD-10 codes have been loaded. For additional information, see the **ICD-10's in Procedure Entry & Edit an Encounter** note under the *Transactions* section of these release notes.

Load ICD-10-CM Codes (*Diagnosis Code Table*) *New Functionality* ***Action Required***

The ICD-10 code set is included in the 7.4.4 release so you will **not** be required to purchase it as you have had to do with prior code sets. You will need to load the ICD-10 codes into the *Diagnosis Code Table* using this function prior to posting 'practice' claims in *Procedure Entry* and using the claim preview function in when using Encounter View to view a patient's account history. For additional information, see the **History – Encounter View** entry under the *Patient* section of these release notes.

Tables (cont.)

Maintain Language Codes (Language Code Table)

To assist in meeting Meaningful Use Stage 2 requirements for EHRs, the *Language Code Table* has been updated to include ISO 639-1 codes, if applicable. Currently, the Language Code Table contains both the ISO 639-2 Bibliographic (B) and ISO 639-2 Terminology {T} codes. Not all languages have ISO 639-1 and/or ISO 639-2 codes, although some language codes contain both. When the ISO 639-1 code does exist, it will be contained within brackets '[']' after the 639-2 Terminology {T}.

Existing Language Codes			
Active	Code	Alternate Description	Standard Description
<input checked="" type="checkbox"/>	alb	Albanian {sqi} [sq]	Albanian
<input checked="" type="checkbox"/>	arm	Armenian {hye} [hy]	Armenian

When an ISO 639-1 code exists, it must be stored in the EHR for the patient's language. The **Alternate Description** has been enhanced to display the ISO 639-1 code denoted in brackets '[']'. For additional information, see the **Patient Name and Address Information** section in the *Patient, Change Patient Data* section of these release notes.

Maintain Location Codes (Location Code Table)

The internal **Place of Service Code** list has been updated with three new codes:

- Walk-in Retail Health Clinic (17)
- Ambulance - Air or Water (42)
- Res Substance Abuse Treatment Ctr (55)

The code for *Prison/Correctional Facility (10)* has been removed and any existing Place of Service Code that was set to it has been changed to *Prison/Correctional Facility (09)*.

HCFA Place of Service Code	OFFICE (11)
MED Place of Service Code	INDEPENDENT CLINIC (49)
DMERC Place of Service Code	INDEPENDENT LABORATORY (81)
MD Place of Service Code	INDIAN HEALTH SERVICE/FREE STANDING (05)
REVENUE Place of Service Code	INDIAN HEALTH SERVICE/PROVIDER BASED (06)
UB Billing	INPATIENT HOSPITAL (21)
UB Type of Bill	INPATIENT PSYCH FACILITY (51)
UB Location Equivalent	INTERMEDIATE CARE/MENTALLY RETARDED (54)
Medicare Prov/Facility Number	MASS IMMUNIZATION CENTER (60)
Medicaid Prov/Facility Number	MILITARY TREATMENT FACILITY (26)
BC Prov/Facility Number	MOBILE UNIT (15)
Location NPI Number	NON-RES SUBSTANCE ABUSE TREATMENT CTR (57)
CLIA Number	NURSING FACILITY (32)
Mammography Certificate	OFFICE (11)
Fee Schedule	OTHER PLACE OF SERVICE (99)
Suppress Encounter	OUTPATIENT HOSPITAL (22)
	PHARMACY (01)
	PLACE OF EMPLOYMENT/WORKSITE (18)
	PRISON/CORRECTIONAL FACILITY (09)
	PSYCH FACILITY-PARTIAL HOSP (52)
	PSYCH RESIDENTIAL TREATMENT CENTER (56)
	PUBLIC HEALTH CLINIC (71)
	RES SUBSTANCE ABUSE TREATMENT CTR (55)
	RURAL HEALTH CLINIC (72)
	SCHOOL (03)
	SKILLED NURSING FACILITY (31)
	TEMPORARY LODGING (16)
	TRIBAL 638/FREE STANDING (07)
	TRIBAL 638/PROVIDER BASED (08)
	URGENT CARE FACILITY (20)
	WALK-IN RETAIL HEALTH CLINIC (17)

Tables (cont.)

Import Fee Schedules (*Fee Schedule Tables*) – *Action Required*****

The Centers for Medicare and Medicaid Services (CMS) have released the 2014 Medicare Physician Fee Schedule effective January 1, 2014. The updated files are available for import by selecting **2014** in the **Fee Schedule Year** list and the applicable file name in the **Fee Schedule File** list.

Load the AMA HCPCS Codes (*Tables, Procedure Code Table*) *Action Required*****

Updates to the 2013 HCPCS data files, effective October 1, 2013 are available for clients who have purchased that code set. To receive the updated codes you must reload the 2013 file.

Load the AMA ICD-9-CM Codes[®] (*Diagnosis Code Table*)

The updated 2014 ICD-9-CM codes, effective October 1, 2013 are available for loading. There were no changes between the 2013 codes and the 2014 codes, so if you have already purchased and loaded the 2013 codes you do not need to load the 2014 codes. If you would like to purchase the 2014 code set, contact customer service.

Transactions

Procedure Entry, Edit an Encounter, and Unposted Procedures

If you have the **Default DX's from Patient's Last Visit** check box selected in the *Procedure Entry Integration* function, up to 12 diagnosis codes will now populate in the **Diagnosis** field. Previously, there was a limitation of only populating up to four diagnosis codes in *Procedure Entry* and *Edit an Encounter*.

A change was also made that affects how and when diagnosis codes are defaulted when a **Case** is selected in *Procedure Entry* and *Edit an Encounter*, including *Unposted Procedures* that are opened and edited in *Procedure Entry*. When you select a **Case** in *Procedure Entry* or *Edit an Encounter*, if you have the **Default DX's from Patient's Last Visit** check box selected the diagnosis codes are defaulted based on the following criteria:

- If the **Case** has been previously posted with any procedures, the diagnosis codes for that encounter will be defaulted.
- If the **Case** has *not* been previously posted with any procedures, if a **Primary Diagnosis** is stored in the **Case** it will be defaulted. (**Note:** if a **Primary Diagnosis** is stored in the Case, it will always be defaulted regardless of whether the **Default DX's from Patient's Last Visit** check box is selected or not.)
- If the **Case** does *not* contain a **Primary Diagnosis**, the diagnosis codes that were originally defaulted will remain in the Diagnosis fields and will not be changed.

Procedure Entry and Payment Entry

The **Insurance** Action Column function on the Procedure Entry Summary screen has been enhanced to handle printing the new CMS-1500 (02/12) form. When you click the **Insurance** Action a message will display indicating which claim format is ready to print (excluding Legacy):

- CMS-1500 (08/05) claims are ready to print.
- CMS-1500 (02/12) claims are ready to print.
- UB-04 claims are ready to print.

If there are multiple claim formats ready to print, you will be instructed to use the *Print Insurance Forms* function to print the claims

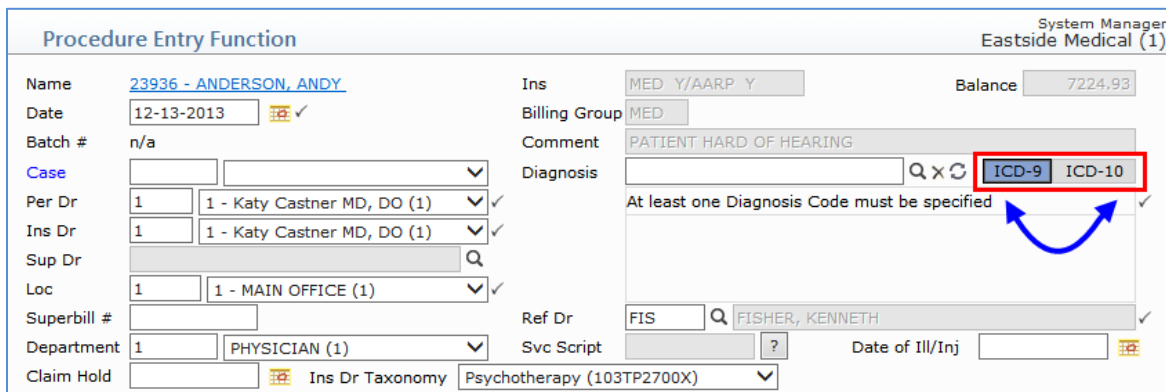
Transactions (cont.)

ICD-10's in Procedure Entry & Edit an Encounter - *New Functionality*

For Phase I of the ICD-10 Updates, a new ICD-10 tab has been added so you can 'practice' using the new ICD-10 Coding Tool and post charges with ICD-10 codes to create 'practice' claims.

Note: You will need to load the ICD-10 codes prior to posting 'practice' claims. The **ICD-10** tab will not display in *Procedure Entry* until the ICD-10 codes have been loaded. For additional information, see the **Load ICD-10 Codes** entry under the *Tables* section of these release notes.

When you access the function, the ICD-10 tab will be located to the right of the ICD-9 tab allowing you to toggle between the ICD-9 and ICD-10 codes. It is not required that you enter ICD-10 codes for each encounter since it is intended to be used when you want to 'practice' using ICD-10 codes. You have a couple of options available when completing the fields on the Procedure Entry screen. You can complete all of the fields on the screen first, including the ICD-9 codes and then toggle to the ICD-10 tab, or you can select the ICD-10 tab first and then complete all of the fields. Either way, the ICD codes are the only fields that are stored separately. You only need to complete the remaining fields one time and when you toggle between the two ICD tabs; the remaining fields will remain populated. It was designed this way to eliminate the need for double-entry of data.



The screenshot shows the 'Procedure Entry Function' window for 'System Manager Eastside Medical (1)'. The patient name is '23936 - ANDERSON, ANDY' and the date is '12-13-2013'. The diagnosis field is currently empty, but it has two tabs: 'ICD-9' and 'ICD-10', both of which are highlighted with a red box. A blue double-headed arrow points between these two tabs. Below the tabs, a message reads 'At least one Diagnosis Code must be specified'. Other fields include 'Ins' (MED Y/AARP Y), 'Billing Group' (MED), 'Comment' (PATIENT HARD OF HEARING), 'Ref Dr' (FIS FISHER, KENNETH), and 'Ins Dr Taxonomy' (Psychotherapy (103TP2700X)).

The diagnosis code selection functionality has been enhanced for both ICD-9 and ICD-10 codes. Typing in either of the **Diagnosis** code boxes (ICD-9 or ICD-10) will now auto-fill the diagnosis results in a window beneath the **Diagnosis** code box. You can search by code, partial code, keyword, and multiple keywords can also be chained together (ex: cat bitten). The field length has been increased to accommodate more characters. You can use the arrow keys to move up and down within the results list or you can use the pointer to select a code in the list. After selecting the code you want, press Enter or the Tab key to add the code to the Encounter screen.

Transactions (cont.)

ICD-10's in Procedure Entry & Edit an Encounter (cont.)

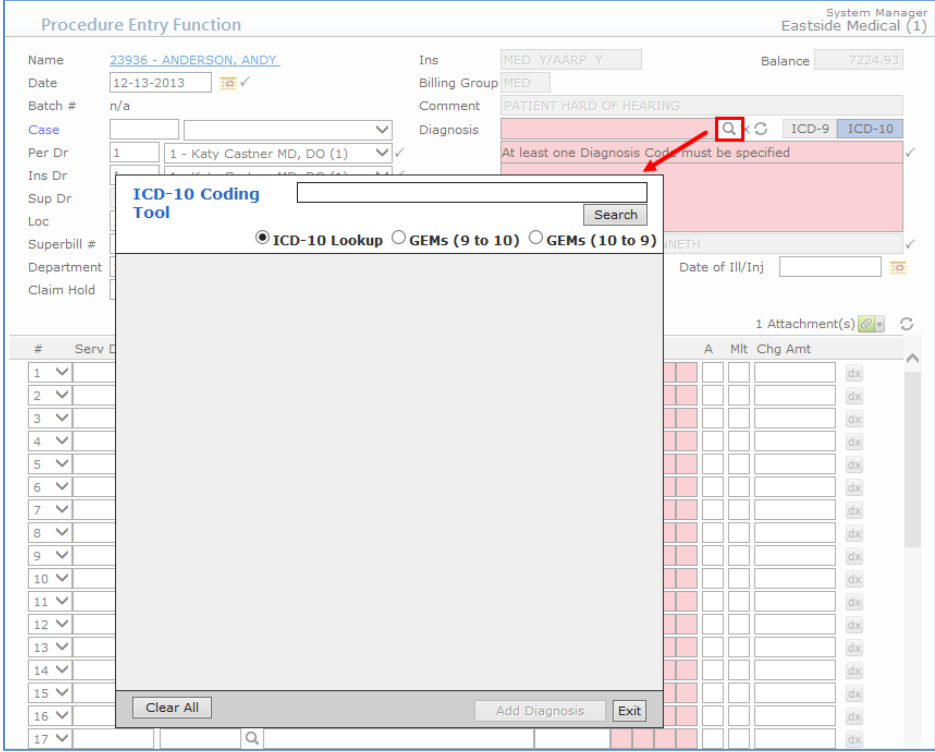
ICD-9 Example

Ins	MED Y/AARP Y	Balance	7224.93
Billing Group	MED		
Comment	PATIENT HARD OF HEARING		
Diagnosis	cat	ICD-9	ICD-10
	078.3 - CAT-SCRATCH DISEASE		✓
	477.2 - ALLER RHINITIS ANIMAL DANDER		
	692.84 - DERMATITIS DUE TO DANDER		
Ref Dr			✓
Svc Script			

ICD-10 Example

Ins	MED Y/AARP Y	Balance	7224.93
Billing Group	MED		
Comment	PATIENT HARD OF HEARING		
Diagnosis	cat bitten	ICD-9	ICD-10
	W55.01 - Bitten by cat		✓
	W55.01XA - Bitten by cat, initial encounter		
	W55.01XD - Bitten by cat, subsequent encounter		
Ref Dr			✓
Svc Script	W55.01XS - Bitten by cat, sequela		

A new **ICD-10 Coding Tool** has been provided for those situations that require a more detailed exploration of the ICD-10 codes. This new tool replaces the standard "Diagnosis Search" functionality and can be accessed by clicking the magnifying glass.



Procedure Entry Function

Name: 23936 - ANDERSON, ANDY | Ins: MED Y/AARP Y | Balance: 7224.93

Date: 12-13-2013 | Billing Group: MED

Batch #: n/a | Comment: PATIENT HARD OF HEARING

Case: | Diagnosis: cat

Per Dr: 1 | 1 - Katy Castner MD, DO (1) | ICD-9 | ICD-10

Ins Dr: | At least one Diagnosis Code must be specified

Sup Dr: |

Loc: |

Superbill #: |

Department: |

Claim Hold: |

1 Attachment(s)

ICD-10 Coding Tool

ICD-10 Lookup | GEMs (9 to 10) | GEMs (10 to 9)

Search

Clear All | Add Diagnosis | Exit

#	Serv D	A	Mlt	Chg Amt	dx
1					dx
2					dx
3					dx
4					dx
5					dx
6					dx
7					dx
8					dx
9					dx
10					dx
11					dx
12					dx
13					dx
14					dx
15					dx
16					dx
17					dx

The search functions in the same manner as the ICD-9 and ICD-10 Diagnosis search where you can search by code, partial code, keyword, or chain together multiple keywords with the results auto-filled in a list. When you select a code from the results list, all of the detailed information for the code will be displayed. For a detailed explanation of each field shown in the next image, see Appendix C of these release notes.

Transactions (cont.)

ICD-10's in Procedure Entry & Edit an Encounter (cont.)

ICD-10 Coding Tool

Code: M84.361

Brief Description: Stress fracture, right tibia

Description: Stress fracture, right tibia

Incomplete/Complete (I or C): I

Effective Date: 10-01-2013

Category: M84 - Disorder of continuity of bone

Category Excludes 2:

Section #1: Disorders of bone density and structure (M80-M85)

Section #2: Osteopathies and chondropathies (M80-M94)

Buttons: Clear All, Add Diagnosis, Exit

To add the diagnosis code to the Encounter screen, click **Add Diagnosis** or if you want to perform a different search, click **Clear All**.

Procedure Entry Function

Name: 23936 - ANDERSON, ANDY

Date: 12-13-2013

Ins: MED Y/AARP Y

Billing Group: MED

Balance: 7224.93

Comment: PATIENT HARD OF HEARING

Diagnosis: 1 - Katy Castner MD, DO (1) | 1 - M84.361 Stress fracture, right tibia

ICD-10 Coding Tool

Code: M84.361

Brief Description: Stress fracture, right tibia

Description: Stress fracture, right tibia

Incomplete/Complete (I or C): I

Effective Date: 10-01-2013

Category: M84 - Disorder of continuity of bone

Category Excludes 2:

Section #1: Disorders of bone density and structure (M80-M85)

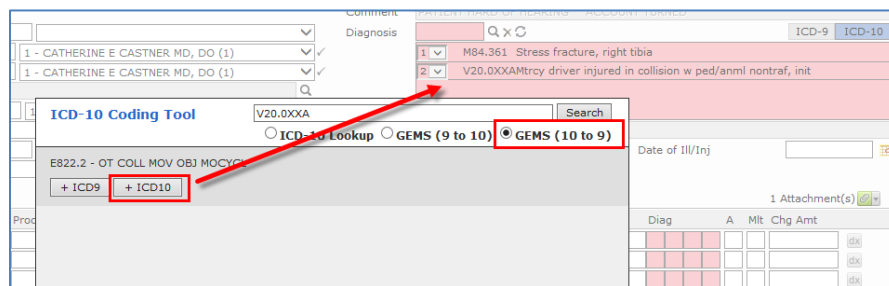
Section #2: Osteopathies and chondropathies (M80-M94)

Buttons: Clear All, Add Diagnosis, Exit

Transactions (cont.)

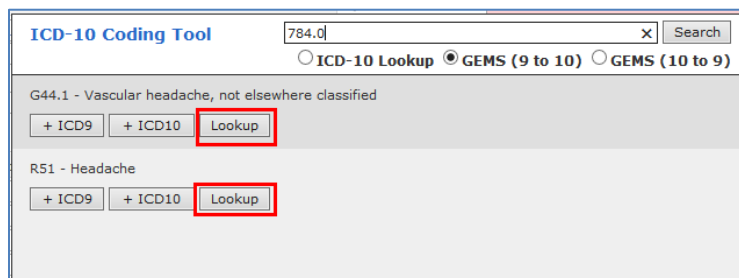
ICD-10's in Procedure Entry & Edit an Encounter (cont.)

The ICD-10 Coding Tool also provides the General Equivalence Mappings (GEMs), as created by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). This is a crosswalk function for looking up the ICD-9 equivalent codes for ICD-10 codes and vice versa. You can either select the GEMs option you want and then type or select a code or you can type or select a code and then click the GEMs option you want. Either method is acceptable. After clicking **Search**, the equivalent ICD code will be displayed. You can add it to the ICD-9 or ICD-10 Encounter screen (whichever is applicable) by clicking either the or button.



Note: The ICD-10 Diagnosis code box and pointer fields will display in red to denote that they are currently for preview purposes only and the codes will not be sent on the claim.

The GEMs (9 to 10) option provides an additional **Lookup** button that provides a shortcut for accessing the **ICD-10 Coding Tool**.







When you have added the diagnosis codes to the Encounter screen and are done using the ICD-10 Coding tool, click **Exit** to continue with entering the procedure line items. The functionality for adding procedures has not changed with the 7.4.4 release, except that both the ICD-9 and ICD-10 diagnosis pointers must be managed separately, as they can and will vary. Entering a procedure line item will automatically fill in the diagnosis pointers for both ICD-9 and ICD-10 codes. After the Encounter has been saved and after insurance has been created, both the ICD-9 and ICD-10 codes will display when you review the patient's transaction history. You can use the **ICD-10 Preview** Encounter Action to preview the 'practice claim' in Encounter View. For additional information, see the **History - ICD-10 Codes** entry under the *Patient* section of these release notes.


Transactions (cont.)

Procedure Entry – UB-04 Attachment

The following fields in the UB-04 Attachment have been updated to Table look-up fields:

- Admit Diagnosis Code Box 69
- Patient Reason Dx Box 70A
- Patient Reason Dx Box 70B
- Patient Reason Dx Box 70C
- External Cause of Injury Box 72A
- External Cause of Injury Box 72B
- External Cause of Injury Box 72C

Encounter Attachment: UB-04 Information (5010 Only)	
Admit Diagnosis Code Box 69	<input type="text"/> 
Patient Reason Dx Box 70A	<input type="text"/> 
Patient Reason Dx Box 70B	<input type="text"/> 
Patient Reason Dx Box 70C	<input type="text"/> 

Note: For the first phase of the ICD-10 updates, you will only be able to search and select ICD-10 codes in *Procedure Entry* and the *Maintain Diagnosis Codes* functions. In every other function that provides the diagnosis code search capability, the **Search** icon  will only search through the ICD-9 codes currently stored in the table even if the new ICD-10 codes have been loaded. For additional information, see the **ICD-10's in Procedure Entry & Edit an Encounter** entry under the *Transactions* section or the **Maintain Diagnosis Codes** entry under the *Tables* section of these release notes.

Print - Procedure Entry Summary Screen

An issue has been resolved where the modifiers were not printing correctly on the walkout statement.

Procedure Entry *webCoder clients only*

Enhancements have been made to the **Check Codes on Save** functionality and **webCoder** website function. webCoder now pulls the **State** code from the **Location Code** that is posted on a procedure to allow the return of more accurate results when doctors happen to practice in multiple states. If a **State** code does not exist for the **Location Code** in the *Location Code Table* or is not available (for example: charges received via an interface), the state stored in the **LMRP State** field in the *webCoder Integration* will be used, as usual.



Transactions (cont.)

Procedure Entry *webCoder clients only*

If your **User Code** has the **Check Codes on Save** option selected in the *webCoder Integration* function, you will now have the option to continue posting charges without checking the codes using webCoder. Previously, if you clicked **Save** in *Procedure Entry* and the NPI/UPIN # for the **Ins Dr** selected did not exist for any of the Doctors selected in the *webCoder Integration* function; you would not be able to **Save** the charges.

ADDITIONAL 7.4.4 RELEASE NOTES

Billing

Create Insurance File

Effective January 1, 2014 it became mandatory that clinical trial numbers be reported on Medicare claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1. Enhancements have been made to make sure all Institutional and Professional claims include clinical trial numbers when the **Demonstration Project Identifier (NCT) Attachment** is completed.

Medicare requires an NCT (National Clinical Trial) number when the following criteria are true:

For Institutional paper and electronic claims:

1. **Condition Code 30** is entered in any one of the Condition Code Boxes 18 through 28; **and**
2. **ICD-9 code of V70.7/ICD-10 code Z00.6** is entered as either the first or second diagnosis code at the claim level in the top portion of the **Procedure Entry** screen; not as diagnosis pointer positions on any of the procedure line items; **and**
3. Encounter contains the **Modifier Q0 and/or Q1**, as appropriate (outpatient claims only).

For Professional paper and electronic claims:

1. **ICD-9 code of V70.7/ICD-10 code Z00.6** is entered as either the first or second diagnosis code at the claim level in the top portion of the **Procedure Entry** screen; not as diagnosis pointer positions on any of the procedure line items; **and**
2. Encounter contains the **Modifier Q0 and/or Q1**, as appropriate (outpatient claims only).

Note: Per article (SE1344) released by Medicare: from Jan 1, 2014 - Dec 31, 2014, providers, physicians, and suppliers who do not have the capacity at this time to report the clinical trial number may instead report an 8-digit, generic number of 99999999. The field cannot be left blank. Beginning January 1, 2015 and without further notice, the actual clinical trial number will be required and the 99999999 will not be accepted.

Transactions

Import and Post ERA Files (Electronic Remittance Advice (ERAs))

Enhancements have been made to comply with the *Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice Transactions* effective January 1, 2014, which includes the updated Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) along with the associated Business Scenario codes.

A few changes have been made to the EOB to better identify the CARCs, RARCs and the new Business Scenarios. Previously, the RARCs for a claim were listed in a row labeled **Reason Codes** located below the **PT RESP** row and now they have been moved to print directly below the CARCs in the **GRP/RC** column. If any of the CARCs and RARCs sent by the payer fall into one of the Business Scenarios, a row labeled **BUSINESS SCENARIOS** will be listed below the **PT RESP** row and the Business Scenarios that are applicable to this patient's service lines will be listed along with the CARC/RARC combination that applies to this Business Scenario. See the image below for an example:

PERF	PROV	SERV DATE	POS NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COPAY/COIN	GRP/RC	AMT	PROV PD
NAME	1029	102912	21 1	NIC 99232 --	ACHT 318 139.00	68.69	0.00	ICN 19123046 13.74	CO 45 CO 116 NS63	MOA MA01,MA18 69.62 0.69	54.95
PT RESP	13.74			CLAIM TOTALS	139.00	68.69	0.00	13.74		70.31	54.95 NET
BUSINESS SCENARIOS: 1 = 116/NS63, 45											
CLAIM INFORMATION FORWARDED TO: MPS - TRICARE FOR LIFE											
TOTALS: # OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT			
48	8240.44	5455.26	253.31	559.15	7516.94	413.56	0.00	413.75			

The Glossary section has been updated and contains three new sections that list out the CARCs, RARCs, and Business Scenarios separately.

Transactions (cont.)

GLOSSARY: Group, Reason, NOA, Remark and Adjustment codes

CO Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.

FR Patient Responsibility. Amount that may be billed to a patient or another payor.

OA Other Adjustment

PI Payer Initiated

CARC

CARC CODE	DESCRIPTION
3	Copay amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes FR or CO depending upon liability).
116	The advance indemnification notice signed by the patient did not comply with requirements.
237	Missing medication list.

RARC

RARC CODE	DESCRIPTION
NS63	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
NS14	Consult plan benefit documents/guidelines for information about restrictions for this service.
NR01	IF YOU DO NOT AGREE WITH WHAT WE APPROVED FOR THESE SERVICES, YOU MAY APPEAL OUR DECISION. HOWEVER, IN ORDER TO BE ELIGIBLE FOR A REVIEW, YOU MUST WRITE TO US WITHIN 6 MONTHS OF THE DATE OF THIS NOTICE, UNLESS YOU HAVE A GOOD REASON FOR BEING LATE
NR18	THE CLAIM INFORMATION IS ALSO BEING FORWARDED TO THE PATIENT'S MEDIGAP INSURER. SEND ANY QUESTIONS REGARDING MEDIGAP TO THEM.

BUSINESS SCENARIOS:

1=Additional Information Required ♦ Missing/Invalid/Incomplete Documentation

2=Additional Information Required ♦ Missing/Invalid/ Incomplete Data from Submitted Claim

3=Billed Service Not Covered by Health Plan

4=Benefit for Billed Service Not Separately Payable

Note: Certain combinations of CARCs and RARCs are designated to fall under 4 different Business Scenarios. A CARC is required for a Business Scenario but a RARC is optional, so it is possible for certain CARCs to fall under a Business Scenario without a supporting RARC. A Business Scenario will not be linked to each CARC and RARC sent by the payer since only certain CARC/RARC combinations fall under Business Scenarios.

Modifications were also made to better align the printed data on the EOBs to make it more easily identifiable.

The **Coin** column was updated to the **Coin/Copay** column and will now print the coinsurance and copayment amounts on separate lines. The coinsurance amount will print on the first line and then the copayment amount will print on the second line with an accompanying **GRP** code of 'PR Patient Responsibility' and an **RC** code of '3- Copay amount'.

The **Total** for the **Coin/Copay** column now includes the copayment amount. The **PT RESP** amount will be either the amount provided in the CLP05 segment of the ERA file for auto-posted payments (if supplied) or the sum of the coinsurance, copayment, and deductible amounts.

Transactions (cont.)

PERF	PROV	SERV DATE	POS NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COIN/COPAY	GRP/RC	AMT	PROV PD
NAME		HIC		ACNT 64		ICN 369928		0132261			
									AU 85		
		0417 041712	1	90862 --	85.00	47.50	0.00	0.00	CO 45	37.50	32.50
								15.00	FR 3		
FT RESP	15.00			CLAIM TOTALS	85.00	47.50	0.00	15.00		37.50	32.50 NET
ADJS: PREV PD			AU	85							

These enhancements apply when printing EOBs using either the **Print** Action Column function or the printer icon in the **EOB** column and also when printing the EOB from the patient's transaction history screen. They also apply to ERAs that have been auto-posted or manually posted using the **Payment Entry Function**.

Note: When you print an EOB for an auto-posted ERA using the EOB icon from the patient's transaction history screen, it will only match to an EOB printed from the **Import and Post ERA Files** function if the ERA was posted after the 7.4.4 release was installed. Prior to the installation, the manner in which the adjustment amounts were calculated for printing for manually posted ERAs differed from the auto-posted ERAs and would not necessarily match.

APPENDIX A

Professional Claims Splitting Rules Summary

Dates	Additional Information	Codes/Action
Date of Service (DOS) Prior to 10/1/14		One claim - ICD-9 Codes
DOS On or After 10/1/14		One claim - ICD-10 Codes
Dates Spanning the 10/1/14 Date	From-Through Dates on one line (From 9/30/14 – Through 10/2/14)	Through date is used One claim - ICD-10 Codes
	Multiple Line items on one encounter with DOSs spanning the transition date 9/30/14 – 99213 10/1/14 – 99212 10/2/14 – 99212	Split Claim based on DOS In this example, you would have 2 claims: One claim – 9/30/14 – ICD-9 Codes One claim – 10/1/14 and 10/2/14 – ICD-10 Codes (Unless you have chosen to split claims by DOS in the Billing Profile Rules, then you would have a separate claim for each DOS.)
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	From date is used One claim – ICD-9 Codes

Combined Medicare Learning Network Matters Articles (MLN) MM7492 and MLN SE1325:

*Note that MM7492 was released when the ICD-10 implementation date was still 10/1/13, hence those dates being used.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

APPENDIX A (cont.)

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (<i>incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</i>)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH

APPENDIX A (cont.)

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

APPENDIX A (cont.)

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

APPENDIX A (cont.)

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

APPENDIX A (cont.)

Table D –Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FROM

Important Details

1. Please note that creating multiple/interim claims on a single encounter is not a new concept, and that these instructions will apply to relatively few claims per institution because only claims that span this single implementation date (October 1, 2014) will be impacted.
2. When you split claims for an encounter spanning the ICD-10 implementation date, remember to maintain all charges with the same Line Item Date of Service (LIDOS) on the correct corresponding claim for the encounter.

Single item services whose time-frame cross over midnight on September 30, 2014 (e.g., Emergency Room Visits and Observation) **are not split into 2 separate charges**, rather the single item service should be placed in the claim based upon the LIDOS: 1) For ER encounters the LIDOS is the date the patient enters the ER; and 2) for observation encounters it is the date that observation care begins. (Please refer to the "Medicare Claims Processing Manual", Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)), Sections 180.6 Emergency Room (ER) Services That Span Multiple Service Dates and 290.2.2 (Reporting Hours of Observation for observation services); respectively, for more information about Emergency Department and observation claims. You can find this manual at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> on the CMS website.


- If there is no service for the encounter with a LIDOS on the split claim with an October 2014 date, do not send an October 2014 claim to Medicare for payment.
- If there are services with a LIDOS on the split claim with an October date, but there is no payment allowed on any of the charges (i.e., all charges are packaged), you should maintain a log of these charges for cost reporting purposes.

Emergency Department and Observation Service encounters are the most common scenarios for which CMS has received requests for clarification about interim billing.

APPENDIX B

CMS-1500 (02/12) NUCC Box Changes

The following box changes were made to the **CMS-1500 (02/12) Base Form** in the *Paper Claim Editor* function based on the documentation from *NUCC.org*.

Header –has a Quick Response (QR) code  and the date of 02/12

Box 1 – changed TRICARE CHAMPUS to TRICARE and replaced SSN with ID#

Box 8 – changed ‘PATIENT STATUS’ to ‘RESERVED FOR NUCC USE.’

Box 9b – changed ‘OTHER INSURED’S DATE OF BIRTH, SEX’ to ‘RESERVED FOR NUCC USE.’

Box 9c – changed ‘EMPLOYER’S NAME OR SCHOOL’ to ‘RESERVED FOR NUCC USE.’

Box 10d - changed ‘RESERVED FOR LOCAL USE’ to ‘CLAIM CODES (Designated by NUCC).’

Box 11b – added a 2 character field for a ‘qualifier’ and changed ‘EMPLOYER’S NAME OR SCHOOL’ to ‘OTHER CLAIM ID (Designated by NUCC).’

Box 14 – Changed title to ‘DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) and add a ‘QUAL’ field for a 3 character qualifier.

Box 15 – changed to ‘OTHER DATE’ and added a 2 character field for a ‘qualifier.’

*Box 17 - added a 2 character field for a ‘qualifier.’

Qualifier codes:

–DN Referring Provider

–DK Ordering Provider

–DQ Supervising Provider

Based on the qualifier code used above will determine which provider will print.

Box 19 – changed to ‘ADDITIONAL CLAIM INFORMATION (Designated by NUCC).

Box 21 - added a single character field for the ‘ICD Ind’ of either a "9" or a "0" that indicates if the claim contains ICD-9 or ICD-10 diagnosis codes. Added eight additional lines for diagnosis codes and the line labels were changed to ‘letters’ to allow for accurate DX pointer information.

Box 22 – changed to ‘RESUBMISSION.’

Box 30 - changed to ‘Rsvd for NUCC Use.’

*Box 32b – can now hold state license/provider # or location number

*The following boxes have not been modified and will retain the same settings that were used for the CMS-1500 (08/05) form: 17, 24I, 24J, 32A, 33A and 33B. The requirements for these fields were actually changed by the NUCC when the (08/05) form was released but they were never made within CGM webPractice at that time. The reason for this was because many payers don’t necessarily conform to all of the NUCC requirements and if the changes were made across the board to comply with the NUCC requirements, there would be a higher possibility of incurring claim rejections. CGM is taking the same approach for the new NUCC requirements for the (02/12) version of the form and these changes will not be made within CGM webPractice. If a payer does start requiring changes to any of these boxes in the future, you should contact Customer Service for assistance.

APPENDIX C

Data Definitions for ICD-10 Codes

Field Name	Description
Code	ICD-10 code
Tabular order number	5 digit numbers assigned to the code according to where the code occurs in the coding system. This number will likely change with each update
Brief Description	Short CMS Description
Description	Long CMS Description
Incomplete/Complete (I or C)	I = Incomplete and C = Complete – this indicates whether or not the code is considered “complete” or “incomplete”. An incomplete code is one where further characters are possible.
Effective Date	The date the code became effective
Inclusion Terms	Specific to the code
Includes	Specific to the code
Excludes1	Specific to the code
Excludes2	Specific to the code
Use Additional Code	Specific to the code
Code First	Specific to the code
Code Also	Specific to the code
Code Notes	Notes specific to the code
Category	A category refers to the first three characters of an ICD-10 code (before the decimal point). Information related to a category relates to all codes with same three first characters.
Category Inclusion Terms	Specific to the category
Category Includes	Specific to the category
Category Excludes1	Specific to the category
Category Excludes2	Specific to the category
Category Use Additional Code	Specific to the category
Category Code First	Specific to the category
Category Code Also	Specific to the category
Category Notes	Notes specific to the category
Section	A section refers to a range of codes within multiple categories. Information related to a section relates to all codes within the range of categories listed. While a code may only be included in one category, a code may be included in more than one section. Multiple sections are separated by tilde <~> marks, and the data in columns 21 through 26 is relationally positioned in the same tilde-separated position as the section to which it is related.

Data Definitions for ICD-10 Codes (cont.)

Field Name	Description
Section Inclusion Terms	Specific to the section range listed
Section Includes	Specific to the section range listed
Section Excludes1	Specific to the section range listed
Section Excludes2	Specific to the section range listed
Section Use Additional Code	Specific to the section range listed
Section Notes	Notes specific to the section range listed

Instructional Notations

Inclusion Terms - These are other commonly used terms that are associated with the diagnosis code

Includes - The word 'Includes' appears immediately under certain categories to further define, or give examples of, the content of the category.

Excludes Notes - The ICD-10-CM has two types of excludes notes. Each note has a different definition for use but they are both similar in that they indicate that codes excluded from each other are independent of each other.

Excludes1 - A type 1 Excludes note is a pure excludes. It means 'NOT CODED HERE!' An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Excludes2 - A type 2 excludes note represents 'Not included here'. An excludes2 note indicates that the condition excluded is not part of the condition it is excluded from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together.

Data Definitions for ICD-10 Codes (cont.)

Instructional Notations (cont.)

First/Use Additional Code notes (etiology/manifestation paired codes) - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a 'use additional code' note at the etiology code, and a 'code first' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title 'in diseases classified elsewhere'. Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. 'In diseases classified elsewhere' codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

Code Also - A "code also" note instructs that 2 codes may be required to fully describe a condition but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.

7th characters and placeholder X - For codes less than 6 characters that require a 7th character, a placeholder X should be assigned for all characters less than 6. The 7th character must always be the 7th character of a code.