ADAM

Executive Decisions in

DERMATOLOGY

May/June 2013

Are You Ready for October 1, 2014?

On **<u>October 1, 2014</u>** a key element of the data foundation of the United States health care system will undergo a major transformation. We will transition from the decades old Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes to the far more contemporary, vastly larger, and much more detailed Tenth Edition of those code sets, or ICD-10, used by most developed countries throughout the world. Acting CMS Administrator Marilyn Tavenner has confirmed the **<u>October 1, 2014</u>** deadline and encourages everyone to work diligently toward a successful transition.

The Center for Medicare and Medicaid Services (CMS) has developed ***The ICD-10 Implementation Guide for Small and Medium Provider Practices***. A small physician practice is defined as having one to five physicians and may provide single specialty or multispecialty services. Medium physician practices are standalone clinics not affiliated with a larger health care organization that have 6-20 physicians who provide single specialty or multispecialty, patient care services. They may also provide ancillary services (diagnostic, therapeutic, and custodial care). ***The ICD-10 Implementation Guide for Small and Medium Provider Practice*** groups the milestones and tasks into the following six phases. Planning, communication and awareness, assessment, operational implementation, testing, and finally, transition.

Making the transition to ICD-10 is not optional.
All "covered entities" as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are required to adopt ICD-10 codes for use in all HIPAA transactions with dates of service on or after the **<u>October 1, 2014</u>** compliance date. For HIPAA inpatient claims, ICD-10 diagnosis and procedure codes are required for all inpatient stays with discharge dates on or after October 1, 2014.

Learn more about the transition as it relates to the dermatology specialty on page nine.

Want more? Get a personalized ICD-10 Documentation Assessment from VEI at a special ADAM rate of $300 (normally $400!) Call (317) 621-7197 to set up an assessment for your practice.

In this issue

President's Corner

A series about the state of the Association and what's new with ADAM. Do you have a question for Jayne? Email us at ADAMinfo@shcare.net

Even though summer vacations are upon us, that nagging date of October 1, 2014 is in the back of my mind. ICD-10 isn't going away and ADAM is working to provide you with the best resources for dermatology practices. This edition of Executive Decisions in Dermatology includes two ICD-10 articles as well as information on the newest member benefit: an ICD-10 documentation assessment. Be sure to take advantage of that and other member benefits such as the Linkedin page where members are talking about ICD-10, HIPAA, salary, and more.

Sincerely,

Member Spotlight

Would you like to nominate someone for the Member Spotlight? Email us at ADAMinfo@shcare.net

ADAM: What is your name and where do you work?
Toni: Toni Essary, Dermatology Center of Dallas in Dallas, Texas.

ADAM: When did you join ADAM?
Toni: I have been a member for 16 years.

ADAM: How long have you been a practice manager?
Toni: I have been a practice manager with Dermatology Center of Dallas for 16 years and a practice manager for almost 25 years.

ADAM: What has been your best experience being an ADAM member?
Toni: Networking with other managers has been very rewarding. I enjoy getting to know other colleagues, and gaining valuable input on current issues, products and cosmetic procedures.

ADAM: As a practice manager what do you find to be the most challenging part of your job?
Toni: Personnel management is the most challenging area of my job. I want to motivate and encourage employees to focus on service excellence. The changing health care environment adds to this challenge.

ADAM: What would you recommend to a member who is looking to be more involved?
Toni: I would encourage members to attend the Annual Meeting and join LinkedIn. Both of these resources have been valuable for identifying best practices and gaining increased knowledge.

Featured Member Benefit!

Join ADAM-Edge, Supply Chain Savings Program with Henry Schein, *exclusive* to ADAM members. The Program is designed to increase profitability by leveraging member buying power, which will translate to overall lower pricing on medical supplies, pharmaceuticals and equipment. Additionally, ADAM members enjoy a number of services including: Inventory Management, Reporting, Budgeting, Staff Team Building Training and much more!

For more information email Adam-Edge@henryschein.com or visit www.henryschein.com/adam-edge

Upcoming Webinars

Don't miss out on these great learning opportunities. Register at www. ada-m.org

Wednesday, May 29, 2013 3:00pm ET

Automating Your Practice: Clinical and financial software tools to improve practice efficiency and profitability

This webinar will help you compare and contrast manual versus automated administrative, financial and clinical processes and workflows and serve as an introduction to automation tools, including credit and debit card processing, device interfaces, reporting dashboards, HIPAA-compliance data backup, statement processing and collections, that can be integrated into PM and EMR software. Learn how automation tools and services can be used to **improve efficiency** and **profitability**, as well as discover guidelines on conducting a needs analysis, best practices for purchasing, implementation recommendations, setting and managing expectations and post-implementation measurement for continuous improvement initiatives.

Thank you to Micro MD, a division of Henry Schein Medical for providing this webinar.

Wednesday, June 26, 2013 3:00pm ET

Benchmarking for Dermatology

Join Jason Keller, Director of VEI Consulting as he discusses how benchmarking can help your practice. How well does your practice collect revenue and how well does it control costs? Jason will go over how to use these four benchmarks:

1. Net Collection Rate
2. Overhead
3. Work Relative Value Units
4. Rate the Answer to "Would You Recommend This Practice to Others?"

Thank you to VEI Consulting for providing this webinar.

Linkedin Hot Topics

Don't forget to use the "search" function to find previous discussions on great topics like salary, HIPAA, EHR, and more!

Congratulations to our most active user contest winners: Gabi Brockelsby, Angela Short, Janice Smith, and Terri Esposito!

Does anyone have an office policy offering reduced services for patients in financially difficult positions?

Melanoma Monday is May 6th. Is anyone promoting this through their practice?

Does anyone send their providers to see patients in nursing homes?

Employee Engagement: Motivating the Managed

Alisha Merlo, ProMD Solutions

Is your office staff made up of top performers who are resourceful, productive and excited to be at work? Do they feel a profound connection to the practice and have the drive and innovation to move the organization forward?

> *According to the Gallup Employee Engagement survey only 29% of the workforce falls into this category. Over 70% are either disengaged or actively disengaged. This means lost productivity that costs the US over $370 billion dollars a year.*

Non-engaged employees do the bare minimum of what is expected, they do not make an extra effort, and they do not think outside the box. These employees have low productivity, are just putting in time, and show no energy or passion. Disengaged employees aren't just unhappy at work; they are busy acting out their unhappiness. Every day, these workers undermine what their engaged coworkers accomplish.

The best way to reengage an employee is by finding what motivates them. What makes them tick?

With so many different personality types, and behavioral styles, it can be difficult to identify motivating factors for each employee. If employees came with instruction manuals, we could easily set up, install, program and trouble shoot. If only!

One way to understand the motivating factors of your employees is to remember the 'how' and 'why' of what we do. These can be defined as behaviors and motivators. Behaviors are observable. They are how we respond to situations in the work place like those below:

- Problems and challenges
- People and contacts
- Pace and consistency
- Protocol and compliance

Let's dig a little deeper into each of these situations. I will discuss different ways an employee could react to situations so that we as practice managers can anticipate behaviors of staff and use those reactions to your advantage and their benefit.

Problems and Challenges

Some people face problems and challenges head on. They always seem to be ready to take charge and press on. Others may want to work more collaboratively as a team and shy away from conflict. The latter approach does not necessarily indicate disengagement but rather a different means to an end.

People and Contacts

Some employees are "people, people." They love to talk and are always enthusiastic, optimistic and social. Others may be more reflective, logical, operationally focused and critical. By taking a few minutes to understand each employee's personality traits, you will be better able to keep them engaged.

Pace and Consistency

Some may prefer a predictable, consistent, steady pace. They are patient and relaxed and can be resistant to change. While others are active, mobile, restless, like a variety of activities and always move at a fast pace. Both of these personalities have benefits and struggles; try to identify where that employee can improve in their day to day work life in order to keep them engaged. Be sure to not only identify the weaknesses, but also praise the successes. We as managers sometimes forget to congratulate and applaud an employee's accomplishments.

Protocol and Compliance

Some employees are very careful and detail oriented. They are systematic, exact and cautious. While others may break all the rules, and are independent and action oriented. The ideal environment for the high detailed staffer is one where critical thinking is rewarded and quality and standards are important. They will perform best with specific direction and a clear understanding of expectations. Those that are more independent can become more frustrated when bogged down with details. To keep them engaged, provide them with opportunities to use their creativity and work independently.

By knowing our individual behavioral style, we can identify and appreciate the personalities of others and learn to adapt to create superior performance.

We view the world through our own filters and when we remove those filters and see others as they are, not better or worse, but just different, we can connect with them and understand what motivates them. We can improve performance management and coaching. We can resolve conflicts and build a stronger team. This improves engagement.

Now that we have identified different ways an employee may react to a situation, we can better understand what caused their reaction. Not everyone is motivated by the same thing. By understanding employee motivating factors you can increase productivity, assign appropriate responsibilities and improve engagement.

The objective of understanding motivators is to identify and appreciate what drives employees, understand and manage how the top motivators can affect employees and learn how goals are helped or hindered by motivators. Do any of the below motivators sound like your employees?

The six key motivators are:

Theoretical

Rewards those who are motivated by knowledge for knowledge's sake, continuing education and intellectual growth.

Utilitarian

Rewards those who are motivated by practical accomplishments, results and rewards for their investments of time, resources and energy.

Aesthetic

Rewards those who are motivated by balance in their lives, creative self-expression beauty and nature.

Social

Rewards those who are motivated by opportunities to be of service to others and contribute to the progress and well being of society.

Individualistic

Rewards those who are motivated by personal recognition, freedom, and control over their own destiny and others.

Traditional

Rewards those who are motivated by traditions inherent in social structure, rules, regulations and principles.

If an individual's strongest motivators are not being met by their workplace they will likely be less engaged. Using validated assessments can help you discover your employees' behavioral strengths and styles and key motivating factors. You can use this information to increase effective communication and engaging your employees. Remember, studies show that engaged employees have less turn-over, decreased sick time and on the job injuries and are significantly more productive at work.

ProMD solutions

Alisha Merlo is Founder and President of ProMD Solutions. To learn more about her practice consulting services click here.

Muddying Guidelines for Billing Modifier 25

By Angela Short, MHA, CPCO, CPCD

According to the American Medical Association's CPT, **modifier 25** should be appended to an evaluation and management service to identify that on the same day as a procedure, that the E/M is "a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed." On the surface, this definition appears straight forward, but after applying the vast number of payer guidelines to this definition, the appropriate use becomes as clear as the mud in a spring garden.

Providers should not fear billing an E/M with a procedure, as long as the service was clearly distinct from the procedure. For example, the patient comes to the office with a mole on the back, and also complains of itching on the hand where the patient communicates that he/she has been recently clearing weeds. The provider evaluates the mole and determines that a biopsy was necessary, and evaluates the rash and diagnoses the condition as poison ivy, and writes the patient a prescription. Clearly two distinct services were provided on this encounter, and both an E/M service and biopsy would be appropriately billed. However, in dermatology, not every encounter is this clear.

It is not uncommon as an example, for an acne patient that is in his/her second month of Accutane treatment, and reports to the office and the provider evaluates the patient's laboratory results, ensures I-Pledge is updated, orders next month's medication, provide significant counseling about the medication and furthermore modify the dosage of the patient's medication, but by the way the patient has a very large acne cyst that needs either to be injected or extracted. Is it appropriate to billing an E/M in conjunction with the procedure? Based on CPT's definition of modifier 25, this encounter clearly supports the E/M. When appending modifier 25 to a claim it is important to remember:

⇒ Modifier 25 should not be used every time the provider performs a minor surgical procedure. For example, a patient comes into the office every two or three months for cryotherapy for warts or an injection for an acne cyst. The provider has already established a plan of care, and only the procedure would be reported.

⇒ Modifier 25 should not be used for a scheduled procedure. The provider should bill only the procedure. For example, a patient had an abnormal biopsy and the provider schedules the patient for an excision. It would not be appropriate to report an E/M for this service even though the provider took time to explain the biopsy results to the patient. The decision was already made for the procedure.

⇒ When appending Modifier 25, the medical documentation must support that an evaluation and management service is distinct and medically necessary to be performed. To this end, the documentation must include for an established patient at least two of the three elements of an E/M: History, physical exam, medical decision making.

⇒ The most important thing to remember when billing an E/M in conjunction with a procedure; is whether or not the documentation supports the service as billed. I suggest providers using language such as "in addition, the patient complains of" or "Problem #2" giving a clear indication that something else is going on.

Many payers have identified modifier 25 as a golden opportunity to recoup dollars from healthcare providers, resulting in a growing number of audits. Consistent with audits, the HHS Office of Inspectors General's 2013 audit work plan includes reviews for services billed with modifiers during the global period including work associated with the preoperative and postoperative periods. This means that providers can no longer guess whether or not the visit is appropriate. It is very important to follow payer guidelines closely. If your practice finds that it is subject to an audit, the office should understand the guidelines that the payer was following during the audit period. It would be inappropriate for a health plan to apply 2013 guidelines to services performed in 2007, and it is not uncommon for health plans to reference current day guidelines. It is the offices responsibility and right to pull out historical guidelines used as the reference to support the service billed.

The use of modifier 25 is subjective, and there is no clear cut guideline to follow to have 100% confidence that the service will stand the scrutiny of an audit. Follow ADAM's Linkedin page and post questions that you may have regarding modifier 25.

Going Cosmetic?
by Glenn Morley

This is the first of a three part series on Bridging the Gap Between Derm and Cosmetic.

If you've decided to make the strategic change toward increasing cosmetic lines of service, you're joining a bustling movement. Internists, obstetricians, and other specialists continue to enter cosmetic medicine as an antidote to reimbursement decline and the complexities of medical billing and management. The influx of these physicians makes it more important than ever for dermatologists to clearly differentiate themselves from the pack.

Cosmetic services engender higher expectations and increased patient demands that will force your practice to re-evaluate how it delivers service.

Groundbreaking technologies and revolutionary new products will require you and staff to learn new skills and develop new materials and consistent communication messages. In short, building a successful cosmetic practice, or a blended cosmetic-medical practice, takes skill and will.

Too many practices skip the essential step of analyzing their strengths and weaknesses first, and then wonder why the appointment schedule isn't full. So before you start creating a new marketing brochure, ask yourself these four essential questions.

1. What is the patient's experience in your office today?

Dermatology practices most likely to succeed in the transition from medical to cosmetic or blended practice understand the value of the *patient experience* – from the web site to the first phone call to the last post-treatment visit. Rude staff and ripped chair fabric won't cut it.

Cosmetic patients want a high-end retail, not a low-end retailer. While certainly one can buy wardrobe basics at any clean and tidy basic retailer, the cosmetic patient is looking for the special occasion dress and the personalized attention found at a high-end retailer. If your practice can't deliver an experience that's more like a high-end retailer, your success rate will plummet because *your competitors are already delivering it.*

Take an honest look at the non-clinical aspects of the practice. Ask a few trusted friends to call the office and give you feedback about staff's performance. Ask them to evaluate the style and comfort of your reception area and exam rooms, and recommend improvements. If yours is like most medical dermatology practices, you'll need to budget for some facility improvements and customer service training. The overall experience from decision making to smooth financing options must be synchronized and simplified for the cosmetic patient.

2. Are you prepared to invest in the changes required to go from good to *great*?

Being good is not good enough in the highly competitive, cosmetic medical world. The meteoric rise of cosmetic treatment options and non-specialist physicians who market themselves as "cosmetic surgeons," "aesthetic surgeons," and "laser surgeons" makes it essential for dermatologists to deliver the right treatment expertise, credentials, and outcomes – and effectively communicate their value to patients in a way they can understand it.

The most successful cosmetic dermatologists recognize that acquiring new, advanced skills is an ongoing process. They also realize that going from good to great doesn't just mean improving their clinical chops: *Assessing your personal style and ability to relate to patients are both critical components to building lasting relationships with those who seek cosmetic treatment.*

This may mean implementing new consultative processes that include quick financing approvals, investing in photography, marketing, and customer relationship management software, or upgrading your wardrobe. Changing the way you've practiced for years is not always easy. Be prepared for this.

3. How fast can a new patient schedule an appointment?

If your answer is, 'within two weeks,' you are not ready for the cosmetic world. Unlike general dermatology, cosmetic patients can schedule an appointment for Botox® or fillers within a day or so. They are discerning and they don't like to wait. If they can't get on your schedule within a week, they will quietly find another doctor or medispa that will cater to their sense of urgency.

If you are serious about growing your cosmetic business, you must be *very available*. Creating "cosmetic blocks" in your schedule and adding cosmetic patients at the end of the day are starting points to providing the right access.

4. Can your existing team make the 'cosmetic cut?'

The hard truth is: *the team that has been your greatest asset in general dermatology may not be the right team to help you grow a robust cosmetic practice.*

Effective cosmetic practice staff members have a customer service philosophy that goes beyond empathetic medical care. That means traditional practice roles must change. Cosmetic patients don't want to be put on hold. They want to have their questions answered. Some of them like to chit-chat. This means the Receptionist, typically the lowest paid, least trained person in a general medical practice, must become a highly effective concierge/customer support professional.

Cosmetic patients also expect a highly skilled, "go to" or point person who can coordinate their care, help them comfortably navigate financing and payment options, act as a cosmetic resource, troubleshoot issues, and be passionate about the latest cream and antioxidant. In the plastic surgery world this person is called a Patient Care Coordinator. Many dermatology practices can start by appointing a cosmetically savvy staff person as "cosmetic point person" to respond to phone and online cosmetic inquiries, as well as to fan the flame of interest with existing patients.

Going from good to great will take courage and a bias for action. As you set your sights on building a cosmetic or hybrid cosmetic-medical dermatology practice, tackle these tough questions first and you'll unleash the possibility for great success.

Look for the next article in "Bridging the Gap Between Derm and Cosmetic" series: *5 Questions to Ask when the Honeymoon Period Ends.*

Plan to Mitigate Risk for a Smooth ICD-10 Transition

By: Faith C. M. McNicholas, RHIT, CPC, CPCD, PCS, CDC
Manager of Coding & Reimbursement/Government Affairs at the American Academy of Dermatology

In response to a request from the American Medical Association (AMA) to halt implementation of the International Classification of Diseases Version 10 (ICD-10), on February 6, 2013, Acting Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner, reiterated that the deadline for ICD-10 conversion will not change. “We believe the one-year extension to September 30, 2014, offers physicians adequate time to train their coders, complete system changeovers and conduct testing,” she wrote. “Staying the course with ICD-9 is not sustainable in an electronic health environment.”

Since then, CMS has continued urging all healthcare providers to continue planning for ICD-10 transition and implementation**. All claims for health care services provided on or after October 1, 2014, must contain ICD-10 codes.**

Preparing for ICD-10 presents many challenges including the inevitable increases in denials, potential cash flow delays, increased pressure on cash-on-hand, and scrutiny of operating margins. Besides training staff on the new codes, and restructuring data, the risks associated with ICD-10 conversion programs reach far deeper into the dermatology practice’s cash flow and budget.

Dermatologists and their office administrators must note that the changes in ICD-10 for dermatology practices are strictly in relation to diagnosis coding (ICD-10-CM). AMA current procedural terminology (AMA CPT) will continue to be the coding system used in any outpatient or physician office setting to report procedural services.

As a result, the switch from ICD-9-CM to ICD-10-CM will impact clinical documentation and coding resources in the practice. Dermatology practices are urged to review and compare the current ICD-9-CM with ICD-10-CM in the practice, to identify what changes and education will be required in order to be ready for the transition.

Similarities between the two systems

Overall, ICD-9-CM and ICD-10-CM are similar in format with regard to guidelines, coding conventions, and rules. ICD-10-CM has an alphabetic index and a tabular list, both of which resemble those in ICD-9-CM. Maintaining the same indented format for both of these lists makes referencing easier. The alphabetic index is an alphabetical listing of terms and their corresponding code. The tabular list is a chronological list of codes based on body system or condition. The tabular list contains categories, subcategories, codes, and descriptors arranged in a numerical hierarchical structure, just as it was in the ICD-9-CM. ***For example:***

ICD-9-CM 1 7 3 3 x

Category **Etiology, anatomical site, manifestation**

ICD-10-CM C 4 4 3 0 X X

Category **Etiology, anatomical site, extension & severity**

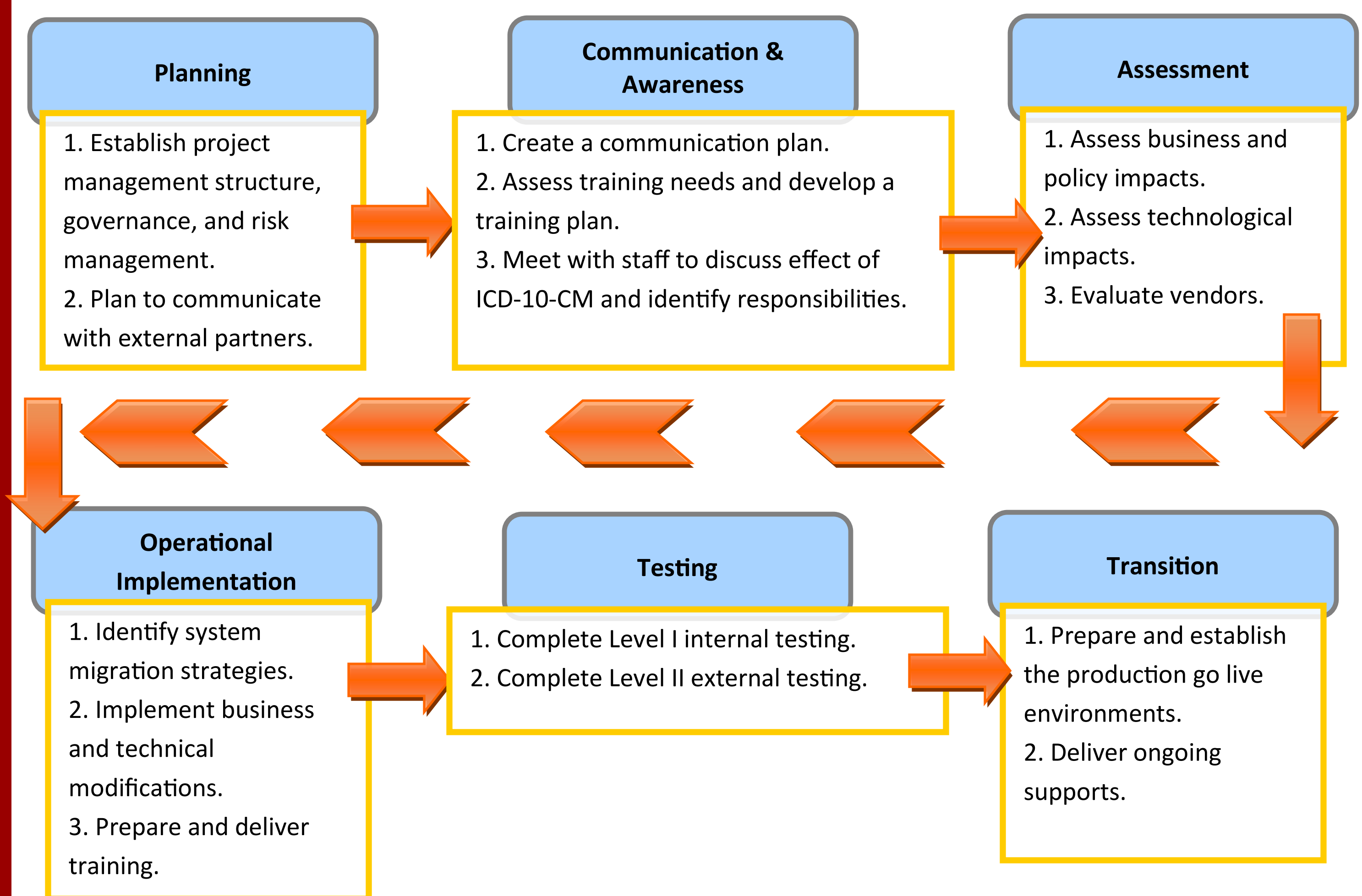
Plan to Mitigate Risk for a Smooth ICD-10 Transition

For successful implementation, dermatology practices need to review and prepare for a smooth transition to ICD-10. If your practice has not already developed a transition and implementation plan, the American Academy of Dermatology (AAD) has some tips on successful implementation of ICD-10 available at http://www.aad.org/member-tools-and-benefits/practice-management-resources/coding-and-reimbursement/icd-10 You can also purchase the Coding Manual in the AAD Store at the member price by using the promo code ADAM13 at checkout!

There will be a period when dermatology practice coding systems will need to access both sets of codes for a period of up to two years as the country transitions from one code set to the other one. Bear in mind that the code selection will be date-of-service driven, e.g., services provided on Sept. 30, 2014, will be reported with ICD-9-CM codes (even if the claim is submitted on Oct. 1, 2014). Services provided on Oct. 1, 2014, will be reported with ICD-10-CM codes only. However, dermatologists may want to hold off on offering training for the new coding system because the ICD-10-CM codes are still evolving and will not be frozen/permanent until Oct. 1, 2014.

Getting up to date with diagnosis codes that may change through next fall and won't take effect until fall 2014 may be confusing for staff who still have to work with ICD-9-CM. Coding professionals recommend that training should take place about six months prior to the Oct. 1, 2014, compliance date.

This transition will require business and systems changes throughout the health care industry. All providers covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition. **Planning now will help your practice make the transition to ICD-10-CM smoother.**



Below are some helpful steps to consider for successful and smooth transition to ICD-10:

	Status	Action
Phase 1: Preparation	**Identify how your Practice is currently using ICD-9-CM**	Identify your current systems and all work processes that use ICD-9-CM codes. This may include clinical documentation, encounter forms or superbills, practice management system, electronic health record system (EHR) and contracts. **Note:** Anywhere your practice is currently using ICD-9-CM codes now will be replaced by ICD-10-CM codes effective Oct. 1, 2014.
Phase 2: Engage Your Business Associates	**Are you Using a Practice Management System?**	Consider immediately starting a dialogue with your practice management system vendor about accommodations for transitioning and implementation ICD-10 code sets; encourage them to take action now to avoid reimbursement delays. Find out what updates are scheduled for your practice management system, and when these are expected to be implemented/installed/completed. Review your contract and verify whether system upgrades are included as part of your agreement or whether this entails additional costs to your practice. In the process of making a practice management or related system purchase? Check for ICD-10 readiness.
Phase 3: Training and Implementation	**Training**	Assess your staff training needs. Identify which staff in your office will need training and when they will need to know how to assign ICD-10-CM code sets. Sign up for training opportunities and materials that are currently available through professional associations, online courses, webinars, and onsite training etc. It is recommended that training commence approximately six (6) months prior to the October 1, 2014, compliance date.
	Implementation Plan	Discuss implementation plans with all your business associates: e.g. clearinghouse, billing services, and payers to ensure a smooth transition. **Be proactive**, don't wait to contact your payers, clearinghouse and billing service to ask about their plans for ICD-10 compliance. Find out when they plan to be ready for testing of their systems for ICD-10.
	Payers	Find out how the ICD-10 implementation might affect your current contracts. Due to ICD-10-CM increased specificity, it is important to discuss with all your payers to determine if the use of ICD-10 codes will entail any modification to any of your existing contracts.
Phase 4: Assessment and Evaluation	**Work Flows**	Identify potential changes to your work flow and business processes. Consider changes to existing processes such as clinical documentation, encounter forms and quality forms.
	Budget	Estimate time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training. Assess the cost impact of any necessary software updates, reprinting of superbills, training and related expenses.
	Testing	Check with your business associates to see when they will begin testing for ICD-10, then coordinate and schedule your testing accordingly. Allow enough time to test that your claims containing ICD-10 codes can be successfully transmitted/exchanged with trading partners. CMS maintains updated testing dates at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

For current information and resources to help you prepare for the **October 1, 2014** compliance deadline, please visit:

AAD ICD-10 at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

CMS ICD-10 at http://www.cms.gov/Medicare/Coding/ICD10/index.html

AAPC at http://www.aapc.com/icd-10/index.aspx

AHIMA at http://www.ahima.org/icd10/assess.aspx

ADAMinfo@shcare.net

www.ada-m.org

1120 G Street NW, Suite 1000, Washington, DC 20005