



ICD-10

**HOW to TRANSITION
your MENTAL HEALTH
PRACTICE**

WITHOUT FEELING LIKE
YOU'VE BEEN **V0490XA***

* ICD-10 CODE FOR

HIT by A MAC TRUCK

TABLE OF CONTENTS

<u>What's the Code for ICD-10 Success?</u>	1
What Is ICD-10? • DSM-5 • Dual Codes • Terminology Changes Unspecified Codes • Type of Encounter • ICD-10 Coding Guidelines More Changes for Mental Health • Special Considerations for Child Psychiatry Strategies for Success	
<u>Step 1: Get Educated</u>	9
Why Train • Educational Resources • Who to Train When to Train • Where to Find Training	
<u>Step 2: Review Coding & Documentation</u>	11
Documentation Improvement • Code Mapping • Sample Code Map	
<u>Step 3: Analyze Your Workflow</u>	14
Document Review • Workflow Review	
<u>Step 4: Financial Planning</u>	16
ICD-10 Budget • Cash Reserves • Cost Containment	
<u>Step 5: Test, Test, Test</u>	20

WHAT’S THE CODE FOR ICD-10 SUCCESS?

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

What Is ICD-10?

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

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

Table 1. Differences Between ICD-9 and ICD-10

How to Transition Your Mental Health Practice

ICD-10 will impact many areas of your practice and touch every employee. And it will affect your mental health practice in unique ways. Advanced preparation is the key to success.

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

DSM-5

Mental health providers currently use The Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), which includes ICD-9, but it will include ICD-10-CM codes for mental and substance use disorders. ICD-10-CM does not include diagnostic criteria, and the presence of documented DSM-5 diagnostic criteria in patient medical records is used by CMS and private insurance contractors for medical chart quality assessment, audit, and fraud/abuse determinations.

Dual Codes

One of the most significant revisions to the DSM-5 is the inclusion of dual codes for every mental disorder in order to account for the currently used ICD-9-CM codes as well as new ICD-10-CM codes, effective October 2015.

- DSM-5 contains the pertinent data required to assign HIPAA-compliant, ICD-10-CM codes to psychiatric diagnoses for that patient demographic.
- All ICD-10-CM codes are alpha-numeric. In DSM-5, they can be found in parentheses within the diagnostic criteria box for each disorder.
- If there is only one ICD-10-CM assigned to a disorder, it can be found at the top of the Diagnostic Criteria set. For example, Schizophrenia has an ICD-10-CM code of F20.9, it is in parentheses.

- When you look at a disorder in DSM-5, it will appear as below. Note that the ICD-9-CM code and the ICD-10-CM code have already been listed for you:

The diagram shows a grey rectangular box representing a DSM-5 diagnostic criteria entry. At the top right of the box, the word "Schizophrenia" is written in a large, bold, black font. Below the title, the text "Diagnostic Criteria" is written in a smaller font. To the right of "Diagnostic Criteria", the code "295.90 (F20.9)" is displayed. Two yellow callout boxes with black text point to the code: one on the left says "This is the ICD-9-CM code for Schizophrenia" and one on the right says "This is the ICD-10-CM code for Schizophrenia".

Often in mental health, there is more than one code that can be assigned to a disorder, the codes can be found at the bottom of the diagnostic criteria box. This is the case when subtypes are coded.

For example, for schizoaffective disorder, the bipolar type is coded F25.0 and the depressive type is coded F25.1. This appears in the DSM-5 criteria example below:

The diagram shows a grey rectangular box containing text. At the top, it says "Specify whether:". Below this, there are two lines of text: "295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur." and "295.70 (F25.1) Depressive type: This subtype applies if only major depressive episodes are part of the presentation." Two yellow callout boxes with black text point to the codes: one on the left says "This is the ICD-9-CM code for Schizoaffective disorder, bipolar type" and one on the right says "This is the ICD-10-CM code for Schizoaffective disorder, depressive type".

When a disorder is high in complexity, the DSM-5 will indicate that additional information in the form of coding notes and coding tables is provided at the bottom of the criteria box. In the example below, the substance/medication-induced disorders, which are complex, show us the additional coding notes and related information to support the code.

The diagram shows a grey rectangular box containing text. At the top, it says "Specify if:". Below this, there are two lines of text: "With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition)." and "Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizoaffective disorder to indicate the presence of the comorbid catatonia."

How to Transition Your Mental Health Practice

ICD-10-CM codes can also be found in the “DSM-5 Classification” in the front of the manual, and as alphabetical and numerical listings in the appendices. For further information on ICD-10-CM coding updates, the implementation of DSM-5, and questions for DSM staff at the APA, please visit www.dsm5.org.

Reporting Multiple Diagnosis Codes

When coding Mental Health for ICD-10-CM, precedence should be given to the diagnosis that best represents “the Nature of the Presenting Problem/ NOPP” and is most relevant to the purpose for the visit.

It is important to consider that the one diagnosis code that is going to be most significant to report is what is termed the “life-time” diagnosis, (i.e., a patient with chronic schizophrenia presenting for an episode of care because of symptoms of acute anxiety). Best practice is to record the diagnoses in the numerical order in which they appear in the ICD-10-CM classification.

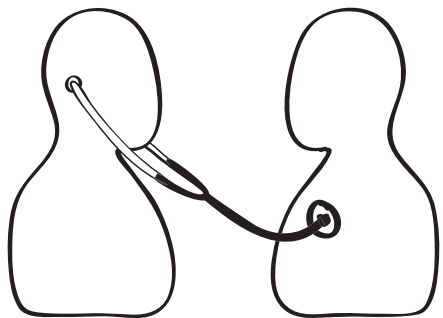
To gain a better understanding of coding of mental health services, the APA will be posting a compendium of ICD-10-CM codes for frequently encountered non-mental health disorders that can be used as a reference for psychiatrists when reporting patient’s comorbid medical diagnoses.

Terminology Changes

Disorder

The term “disorder” is used throughout the classification, in order to keep it separate from terms that often seem to be interchanged as are “disease” and “illness”. The term “Disorder” is not exact, but is referenced here to allow the existence of a clinically recognizable set of symptoms and/or behavior often associated with distress and disruption of personal functions.

Note: Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here.



Psychogenic and Psychosomatic

Psychosomatic disorders found in other classifications can also be classified under the following categories: F45.- (somatoform disorders), F50.- (eating disorders), F52.- (sexual dysfunction), and F54.- (psychological or behavioral factors associated with disorders or diseases classified elsewhere).

Of particular importance is category F54, (category 316 in ICD-9) and remembering to indicate when specifying an association of physical disorders, which are located elsewhere in ICD-10, with emotional causation.

A common example would be the recording of psychogenic asthma or eczema by means of both F54 from Chapter V(F) and the appropriate code for the physical condition from other chapters in ICD-10.

Unspecified Codes

There are practical reasons why a category for the recording of “unspecified mental disorder” is required in ICD-10, but the subdivision of the whole of the classificatory space available for Chapter V(F) into 10 blocks, each covering a specific area, posed a problem for this requirement. It was decided that the least unsatisfactory solution was to use the last category in the numerical order of the classification, i.e. F99.

Type of Encounter

Some ICD-10 codes specify if the encounter is initial, subsequent, or sequela. For example, a patient presents with depression. Physicians must document the type of encounter so coders can assign the 7th (and final) character in the ICD-10 code. An initial encounter is one in which a patient receives initial active treatment. A subsequent encounter is one in which a patient receives routine care during the healing or recovery phase. A sequela encounter is one in which a patient receives treatment for complications or conditions that arise as a direct result of a condition. The [2015 ICD-10 Official Guidelines for Coding and Reporting](#) includes examples of each.

How to Transition Your Mental Health Practice

The type of encounter is required for valid submission of certain codes. Those working in the orthopedic specialty should pay close attention to the 7th character, as it may also include other important information, such as the type of healing (i.e. routine, delayed, nonunion, or malunion).

ICD-10 Coding Guidelines

Physicians who assign their own codes must—at a minimum—read the CDC’s [2015 ICD-10 Official Guidelines for Coding and Reporting](#). This document is a treasure trove of information that includes little known facts about the new coding system physicians could easily overlook. For example, ICD-10 requires inclusion of a placeholder character ‘X’ for certain codes to allow for future expansion. Code category T36-T50 (poisoning by, adverse effects of, and underdosing of drugs, medications, and biological substances) is one example.

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

More Changes for Mental Health

In addition to these broader changes, there are several specific areas where ICD-10-CM differs for mental health providers.

- ✓ **Mental and behavioral disorders due to psychoactive substance use (F10-F19).** Although ICD-9-CM doesn’t distinguish between use, abuse and dependence, ICD-10-CM does. Many of the codes in this section also specify complications such as mood disorders, delusions, delirium, perceptual disturbances, and more.

The ICD-10-CM guidelines have also been expanded to include a hierarchy for reporting purposes. Providers can only submit one code per substance (e.g., alcohol, opioid, cannabis, etc.). This hierarchy states the following:

- If the patient uses and abuses the same substance, assign only the code for abuse.

- If the patient abuses and is dependent on the same substance, assign only the code for the dependence.
- If the patient uses, abuses, and is dependent on the same substance, assign only the code for the dependence.
- If the patient uses and is dependent on the same substance, assign only the code for the dependence.

Mental health providers must clearly document the association of the psychoactive substance with the patient's mental or behavioral disorder.

- ✓ **Pain disorders related to psychological factors (F45.4-).** The ICD-10-CM guidelines have been expanded to include information related to codes F45.41 (pain disorder exclusively related to psychological factors) and F45.42 (pain disorder with related psychological factors). Although these two codes seem very similar, providers should note the following:
 - Code F45.41 denotes purely psychological pain that is not supported by any medical condition.
 - Code F45.42 denotes a legitimate medical pain with a psychological component. When reporting this code, providers should also report the associated acute or chronic pain (G89.-). Note that pain NOS is reported with R52.
- ✓ **Attention deficit hyperactive disorder (ADHD) (F90.-).** ICD-10-CM has been expanded to include the specific type of ADHD (i.e., predominantly inattentive, predominantly hyperactive, or combined). This code expansion, like many others, will be important in terms of research and treatment.
- ✓ **Anorexia.** ICD-10-CM includes separate codes for anorexia nervosa, unspecified (F50.00), anorexia nervosa, restricting type (F50.01), and anorexia nervosa, binge eating/purging type (F50.02). In ICD-9-CM, anorexia nervosa only had one code (307.1).

- ✓ **New Disorders.** Adult Block F60-F69 contains a number of new disorders of adult behavior, including pathological gambling, fire-setting and stealing, as well as the more traditional disorders of personality.

Special Consideration for Child Psychiatry

A number of categories that frequently will be used by child psychiatrists, such as eating disorders (F50.-), nonorganic sleep disorders (F51.-), and gender identity disorders (F64.-), may be located in the general sections under “classifications” due to frequent onset/occurrence in adults and children. However, there are clinical features unique to childhood, which justify the categories of feeding disorder of infancy (F98.2), pica of infancy and childhood (F98.3).

Providers who work within blocks F80-F89 and F90-F98, must be keenly aware of the neurological chapter of ICD-10 (Chapter VI(G)). This chapter houses syndromes with predominantly physical manifestations and clear “organic” etiology, including, Kleine-Levin syndrome (G47.8), which remains high on the list for interest to child psychiatrists.

Strategies for Success

Mental health providers should review all of ICD-10-CM Chapter 5 (mental, behavioral, and neurodevelopmental disorders) to ensure compliant coding. As with many specialties, mental health diagnoses have expanded and/or include revised code descriptions. Specificity is the key to success.

STEP 1: GET EDUCATED

Why Train

Don't assume you can send your coder or biller to training and call it done. 

ICD-10 affects virtually everyone in the practice in some way. It is important for everyone to learn how ICD-10 may affect their role—only then can you plan education and training accordingly.

Practice Manager

New Policies • Updates to Payer Contracts • Budgeting/Financial Planning • New Forms/Software Changes

Front Desk

Prior Authorizations

Billing & Coding

Payer Changes • Coding Changes • Software Changes

Clinical Providers

Coding Changes • Documentation Changes • Software Changes

Educational Resources

Get everyone up on the basics with these resources:

www.kareo.com/icd-10

www.roadto10.org/

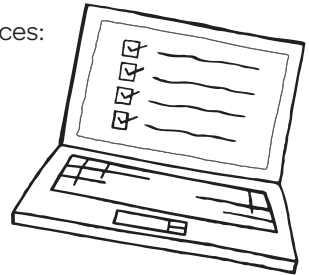
www.cms.gov/ICD10

www.ama-assn.org

www.himss.org

www.icd10watch.com

www.aapc.com



Order the ICD-10 coding handbook for training and evaluating the equivalent codes for your ICD-9 codes. Here are a couple of good tools:

- [ICD-10-CM 2015 Codebook](#) from the AMA
- [ICD-10-CM Mappings 2015](#) from the AMA

How to Transition Your Mental Health Practice

Who to Train

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

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

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

When to Train

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

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

Where to Find Training

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

Physicians can get the education they need from medical societies and software vendors. There are even CME courses available in some cases.

Talk to your [practice management, billing](#), and [EHR](#) vendors about software changes, what training will be available for users, and when it will occur.

STEP 2: REVIEW CODING & DOCUMENTATION

Documentation Improvement

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

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

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

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

How to Transition Your Mental Health Practice

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

Code Mapping

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

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

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

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

Sample Code Map

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

Rank	ICD-9 Codes	ICD-9 Diagnosis Description	ICD-10 Codes	ICD-10 Description
1	296.36	Major depressive affective disorder recurrent episode in full remission	F33.42	Major depressive disorder, recurrent, in full remission
2	300.00	Anxiety state, unspecified	F41.1	Generalized anxiety disorder
			F41.8	Other specified anxiety disorder
			F41.9	Anxiety disorder, unspecified
3	311	Depressive disorder not elsewhere classified	F32.0	Major depressive disorder, single episode, mild
			F32.1	Major depressive disorder, single episode, moderate
			F32.2	Major depressive disorder, single episode, sever without psychotic features
			F32.3	Major depressive disorder, single episode, sever with psychotic features
			F32.4	Major depressive disorder, single episode, in partial remission
			F32.5	Major depressive disorder, single episode, in full remission
			F32.8	Other depressive episodes
			F32.9	Major depressive disorder, single episode, unspecified

Table 2. Sample Code Map Excerpt

STEP 3: ANALYZE YOUR WORKFLOW

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

Document Review

The first change in process took place in January 2014 with the release of the new CMS 1500 v02/12 paper claim form. CMS now requires the use of this form. Other payers will transition at their own pace so you may be using two versions on the CMS 1500 form for a period of time.

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

Workflow Review

This is a significant change to the way you document and code visits and bill payers. As with any change in the clinical process, there may be delays as providers get used to changing documentation and coding. This could be true for billers and coders as well. They will probably find that they have to request additional information from providers and spend a little more time completing claims.



In addition, since there is no way to know how well your payers will do with the change, your billing staff could also be spending more time on claim follow up for a period of time. It's worth your while to plan for an increase in workload for billing staff for at least a short period of time.

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

STEP 4: FINANCIAL PLANNING

ICD-10 will impact your revenue—both now and after the transition. 

There is more to this change than training and code mapping—your practice may not survive without thoughtful financial planning.

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

1. Planning for added expenses related to training and preparing for the transition.
2. Identifying what you will need for cash reserves to protect your practice in the event of a reduction in revenue and productivity. You'll need to save that money or work with your bank to establish a line of credit.
3. Looking at ways to contain costs and reduce expenses in case you do see a revenue shortfall.

ICD-10 Budget

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

Cash Reserves

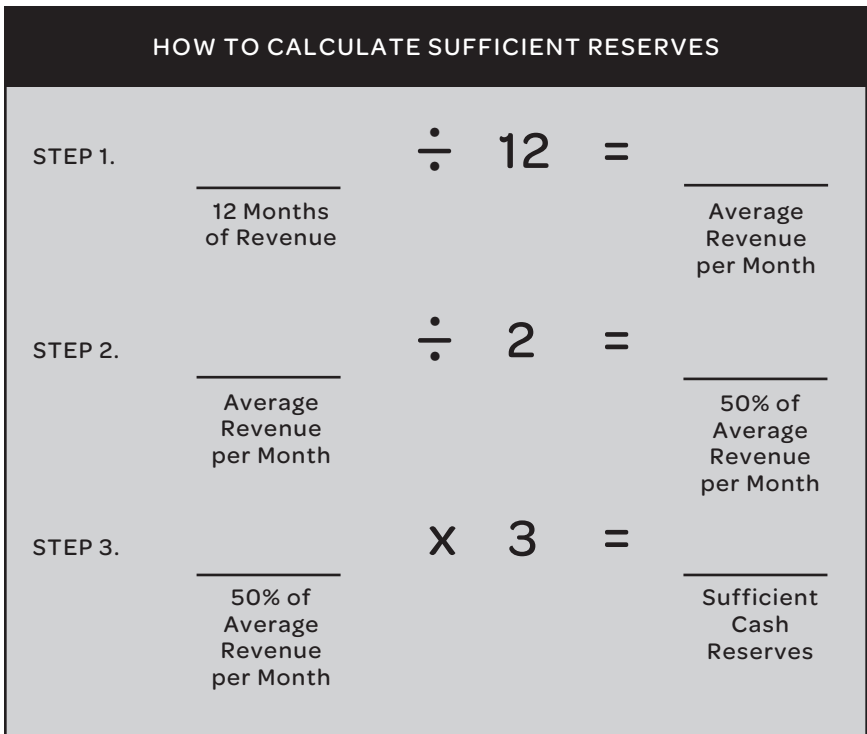
Many experts are suggesting that you should expect to see a reduction in productivity and revenue for about three months of up to 50% (and some say as much as six months). You're a small business with bills to pay so you need to plan for a potential loss of revenue. If you can't pay your rent, utilities, and employees, it will be hard to keep the doors open.

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

Table 3. Sample Budget Spreadsheet

The more prepared and well trained you are, the less impact ICD-10 should have, but you can't predict how the transition will go with your payers. While your own staff may do fine, there could be delays with payers that you can't do anything about. If you can set aside enough cash reserves (or qualify for a line of credit) before October, 2015, then you'll be prepared for whatever happens. Use the following steps to plan:

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



Cost Containment

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

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

1. **Reduce Utilities.** You should always be looking at ways to minimize costs for electricity, Internet, phones, etc. Watch for competitive rates and special offers that may reduce these expenses.

2. **Review Contracts and Leases.** Review all your vendor contracts and leases each year and get competitive quotes from at least two or three other vendors. Also, look for ways to reduce usage for printers, copiers, and other equipment. With more automated solutions, some of these items may become obsolete.
3. **Automate or Outsource Processes.** If you are still doing many practice management, billing, and clinical tasks manually, now is the time to automate or outsource. For example, manually processing paper statements can easily cost two or three times what it costs to use a statement service. Using a medical billing service is often a less expensive alternative to having full time billing staff and can improve your overall collections. According to the Medical Group Management Society, using an integrated practice management and EHR solution can increase your revenue by almost 10% while also reducing expenses for many supplies and time spent on previously manual tasks.

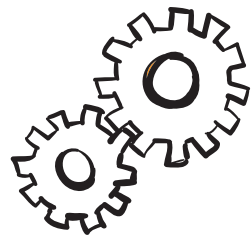
You may wonder why the largest expense of all—staffing costs—is not included above. It's because there are some special considerations around staffing with regard to ICD-10. On the one hand, this is probably not the time for overtime, raises, or bonuses. Wait until after January 2016 to look at that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

STEP 5: TEST, TEST, TEST

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

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

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



Acknowledgements

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Kareo is the only cloud-based medical office software and services platform purpose-built for small practices. At Kareo, we believe that, with the right tools and support, small practices can do big things. We offer an integrated solution of products and services designed to help physicians get paid faster, find new patients, run their business smarter, and provide better care. Our [practice management software](#), [medical billing solution](#), [practice marketing tools](#), and free, award-winning fully certified [EHR](#) help more than 30,000 medical providers more efficiently manage the business and clinical sides of their practices. Kareo has received extensive industry recognition, including the Deloitte Technology Fast 500, Inc. 500/5000, Red Herring Top 100 Company, and Black Book #1 Integrated EHR, Practice Management, and Billing Vendor. Headquartered in Irvine, California, the Kareo mission is to help providers spend their time focused on patients, not paperwork.

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