iCoder User Guide

Medical Association.

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Common Terms and Abbreviations

GPCI

Geographic Practice Cost Index is used along with Relative Value Units by Medicare to determine allowable payment amounts for medical procedures.

AMA

The American Medical Association, founded in 1847 and incorporated in 1897, is the largest association of physicians—both MDs and DOs—and medical students in the United States.

CMS

The Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program.

Coding System

Coding system refers to a set of medical codes that target a specific domain, such as medical procedures, medical diagnostics or medical nomenclature.

Data Download Process

The first time iCoder starts, it will attempt to download all the data it needs to its database. This is done for the purpose of allowing the application to work off-line, and also to make the download from the app store lighter.

What should I do if the download process fails?

In case the download fails, you should verify your internet connection and try again by closing the app and opening it again.

To close the app you can double-tap your home button, look at the app's image and drag it up to close it.

What if I lose my internet connection before downloading the data?

You can close the app and try again when you regain your connection to the internet.

Can the application be used without an internet connection?

Yes, you only need an internet connection when opening the app for the first time or when synchronizing your favorites to iCloud (see below).

Where is iCoder data coming from? How can I trust it?

iCoder data comes from two primary sources:

- The American Medical Association (AMA)
- Centers for Medicare & Medicaid Services (CMS)

Settings

The settings screen allows you to configure iCoder to your personal preferences, the available settings are:
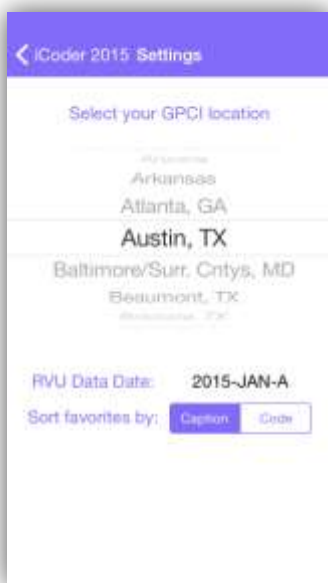
GPCI Location

Geographic Practice Cost Index is used along with Relative Value Units by Medicare to determine allowable payment amounts for medical procedures.

In iCoder the GPCI is used to calculate and retrieve the Facility and non-facility rates.

You can scroll up or down to select your location and all the values will be calculated for it.

RVU Data Date

This setting displays the current date for the CMS relative value unit files that iCoder is using. RVU files change around every 3 months, so with this you can make sure that you are using the correct date. When the files are updated, you will get an update for the app so you can download the latest files.

Favorites Sort Method

This setting controls how the favorites are sorted on the favorite screen:

- Caption: Sorts favorites by their title, which might be the original title on the data or the nickname that you gave it.
- Code: Sorts favorites by their code, which can be its CPT code, or its ICD code if it's an ICD9 or an ICD10.

Categories

The categories screen lists all the procedure code categories found on the CPT, the HCPCS codes and the ICD9 and ICD10.
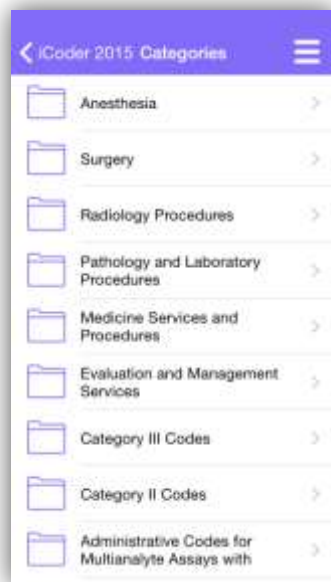
Where is the structure coming from?

The structure for CPTs shown in this categories comes from the AMA, this is how they have structured their codes for use on the current year.

For HCPCS and ICD codes, the structure shown comes from CMS.

How do I use categories?

Tapping each category will give you additional categories and finally the codes that can be found on each one. You can use the back button to return to the previous category. The menu button will lead you back to the main menu.

Tapping any of the codes will lead you to its details and additional information about the code.

Search

The search screen allows you to make searches for codes on the codes in iCoder, including CPT, HCPCS, ICD9 and ICD10.

Performing a Search

To perform a search:
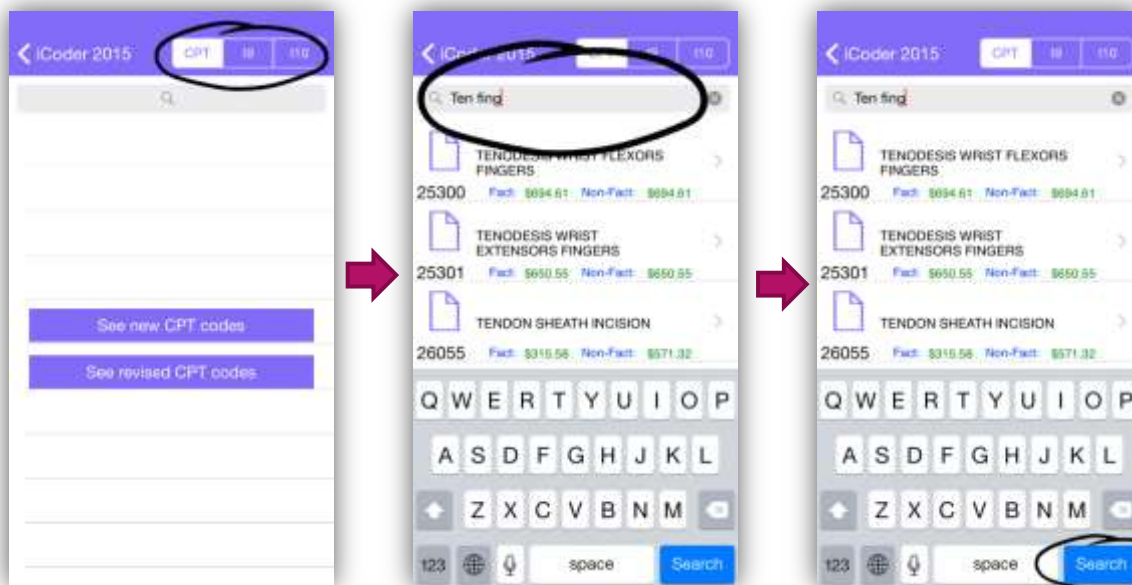
First select the type of search want to perform:

- CPT: Searches both the CPT and HCPCS codes.
- ICD9: Searches for only ICD9 codes.
- ICD10: Searches for only ICD10 codes.

Next, enter the term you want to search for in the search box. You can search either by the specific code, such as typing '493.0' for ICD9 or '99213' for CPT, or you can type one or more terms or keywords separated by a space, such as: 'acute asthma' for ICD10.

When writing your terms, take the following tips into account:

- When entering a code, such as '99213' or '493.01' make sure that you are in the correct search type: CPT ICD9 or ICD10. Also make sure not to type anything other than the code, for example do not type: '99213 visit'.
- Write as little as possible on your term, for example:
  - o If searching the ICD10 instead of typing 'burn to hand' type 'burn hand'.
  - o If searching the ICD10 instead of typing 'pancreatic secretion' type 'pancre sec'.
  - o If searching the CPT instead of typing 'tendon finger' type 'ten fing'

Using this abbreviations will make your search return more results and allow you to avoid typing more than necessary.

- Do not use common words in search, such as 'to', 'from', 'and', 'of'. You should just type the specific keywords that you are looking for as shown above.

To complete your search, use the 'Search' button that appears on your onscreen keyboard.

Search Results

Once your search is complete, you will be presented with a list of results. When looking for a CPT code you will see the code that you are looking for and the codes that are near that code, which means the codes that are before it and after it on the CPT. This allows you to better select the proper code based on the results.

To see the details of a result simply tap it and you will be presented with its details screen.

For CPT codes you will see the Facility (Fact) and Non-Facility (Non-Fac) rates displayed on the search results.

What if I can't find the code that I'm looking for?

If after following these tips you still cannot find the code you are looking for, there are a couple of possibilities:

- The code you are looking for have been removed. Since codes change every year there is always the possibility that the code was removed for the year.
- The code was revised. Sometimes a code is revised either its number or its description. To see revised codes you can tap the 'See revised CPT codes' on the search screen.
- There is a data problem on the application. If you find that the code exists on other services, such as in the CPT book or on the AMA's web site but not on iCoder, please contact us using the built-in feedback system or emailing us at softwaresupport@starinix.com.

New and Revised Codes

iCoder contains functionality to show new and revised CPT codes for the current year.

To see new CPT codes go to the search screen and tap the 'See new CPT codes' button.

To see revised CPT codes go to the search screen and tap the 'See revised CPT codes' button.
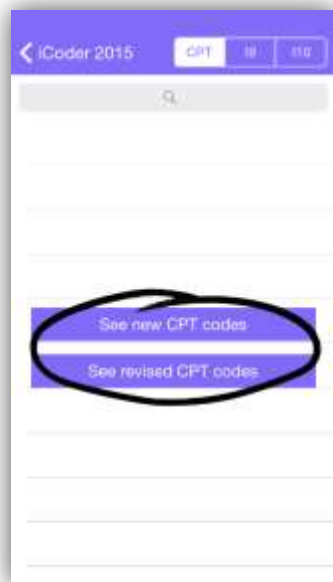
Viewing code details

Whenever you tap a code be it a CPT or ICD code, you will get a detail screen which contains a set of data elements for that code. Below is a description of each data element and its purpose.

CPT Detail Elements

CPT Code
This is the code given to this concept by the AMA.

Descriptors
Each CPT code will have a short, medium and full descriptor which describes the concept in various details.

First Appearance
The year when this code first appeared on the CPT.

Reportable
If this CPT code can be used for billing purposes.

Level
PC indicates that this code is at the procedure level.

Citation
Indicates the places where this code has been cited or used.

Additional Guideline
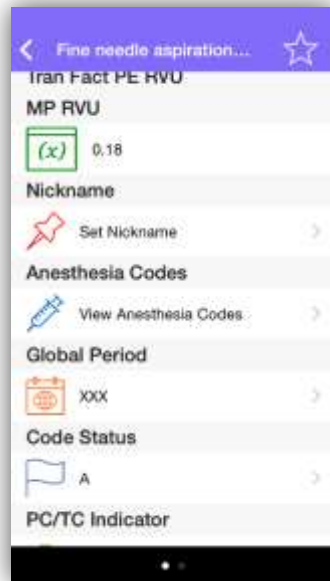Provides additional information on how to use the code. This information is provided by the AMA.

Facility Rate
The rate at which this service will be paid by Medicare for services performed in inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). This rate is calculated using the selected GPCI location.

Non-Facility Rate
The rate at which this service will be paid by Medicare for services performed any other setting other than the ones specified on the facility rate. This rate is calculated using the selected GPCI location.

Work RVU
Relative Value Unit (RVU) for the physician work in the service as published in the Federal Register Fee Schedule for Physicians Services for app's current RVU data year (Available in settings).

Tran Non-Fact PE RVU

Non-Facility Practice Expense RVU, is the Relative Value Unit (RVU) for the resource-based practice expense for the non-facility setting, as published in the Federal Register Fee Schedule for Physicians Services for the app's current RVU data year (Available in settings).

Tran Fact PE RVU

Facility Practice Expense RVU, is the Relative Value Unit (RVU) for the resource-based practice expense for the facility setting, as published in the Federal Register Fee Schedule for Physicians Services for the current RVU data year (Available in settings).

MP RVU

Malpractice RVU, is the RVU for the malpractice expense for the service as published in the Federal Register Fee Schedule for Physicians' Services for the app's current RVU data year (Available in settings).

Nickname

The nickname allows you to set a common name to identify the code when searching or browsing for codes. To set a nick name simply tap the row and enter it. Once you set a nickname you will see this name on the details screen and also when searching and in your favorites.

Global Period

Provides time frames that apply to each surgical procedure. Tapping the row will reveal the description of the value.

Value	Description
000	Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
010	Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
090	Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
MMM	Maternity codes; usual global period does not apply.
XXX	The global concept does not apply to the code.
YYY	The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ	The code is related to another service and is always included in the global period of the other service.

⚑ Code Status

Indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. See table below for description of values. Only RVUs associated with status codes of "A", "R", or "T", are used for Medicare payment. Tapping the row will reveal the description of the value.

Value	Description
A	Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).
C	Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
E	Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.
G	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.
H	Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H". These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.
J	Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services. *Note that you can use the iCoder anesthesia calculator to calculate the rates for this codes.*
M	Measurement codes. Used for reporting purposes only.
N	Non-covered Services. These services are not covered by Medicare.

P	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.
R	Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)
T	Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)
X	Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.
Q	Therapy functional information code (used for required reporting purposes only)

PC/TC Indicator

Professional or technical component indicator. See table below for description of values. Tapping the row will reveal the description of the value.

Value	Description
0	Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
1	Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used

	with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.
2	Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010--Electrocardiogram; Interpretation and Report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.
3	Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.
4	Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.
5	Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.
6	Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

7	Physical therapy service, for which payment may not be made-- Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist.
8	Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to CPT codes 88141, 85060 and HCPCS code P3001-26. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for CPT codes 88141, 85060 or HCPCS code P3001-26 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.
9	Not Applicable--Concept of a professional/technical component does not apply.

Multiple Procedure (Mod 51)

Indicates applicable payment adjustment rule for multiple procedures. Tapping the row will reveal the description of the value.

Value	Description
0	No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.
1	Standard payment adjustment rules in effect before January 1, 1995 for multiple procedures apply. In the 1995 file, this indicator only applies to codes with a status code of "D". If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.
2	Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.
3	=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple

	endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.
4	Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family (per the diagnostic imaging family indicator, below). If procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Pay 100% for the highest priced procedure, and 50% for each subsequent procedure. Base the payment for subsequent procedures on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. The professional component (PC) is paid at 100% for all procedures.
5	Subject to 50% of the practice expense component for certain therapy services.
6	Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter.
7	Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter.
9	Concept does not apply.

Bilateral Surgery (Mod 50)

Indicates services subject to payment adjustment. Tapping the row will reveal the description of the value.

Value	Description
0	150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure
1	150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the

	lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.
2	150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9	Concept does not apply.

Assistant at Surgery

Indicates services where an assistant at surgery is never paid for per Medicare Claims Manual. Tapping the row will reveal the description of the value.

Value	Description
0	Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
1	Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
2	Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
9	Concept does not apply.

Co-surgeons (Mod 62)

Indicates services for which two surgeons, each in a different specialty, may be paid. Tapping the row will reveal the description of the value.

Value	Description
0	Co-surgeons not permitted for this procedure.
1	Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
2	Co-surgeons permitted and no documentation required if the two- specialty requirement is met.
9	Concept does not apply.

Team Surgery (Mod 66)

Indicates services for which team surgeons may be paid. Tapping the row will reveal the description of the value.

| Value	Description
0	Team surgeons not permitted for this procedure.
1	Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report.
2	Team surgeons permitted; pay by report.
9	Concept does not apply.

Guidelines and Body Areas

These are additional browsing categories that provide more information found on the CPT.

The guidelines section can help you make better coding decisions based on the guidelines by the AMA.

The body areas can help you find codes using specific anatomical areas of the body.

Musculoskeletal
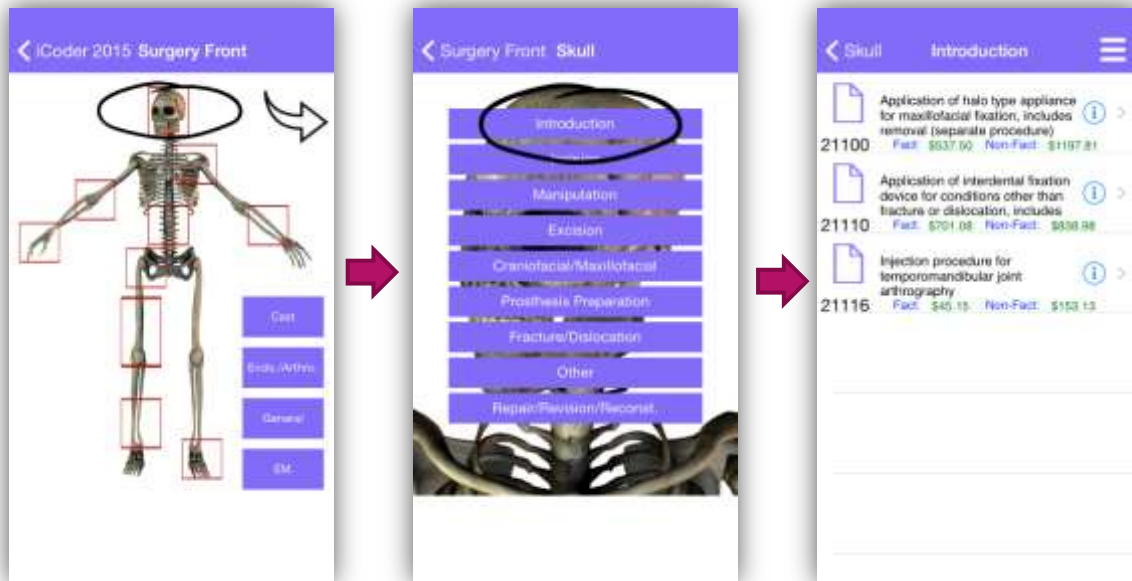
The musculoskeletal browser allows you to browse the CPT using specific areas of the musculoskeletal system.

To use it simply select the area of interest by tapping it on the image. You can use the upper right side arrow to turn the image on its back and access additional areas.

Once an area is selected, you are presented with the possible surgical options for it. Selecting any of these options will yield you the codes or categories that apply.

Favorites

The favorites screen allows you to store your favorite codes for all coding systems in a single place.

Adding a code to your favorites
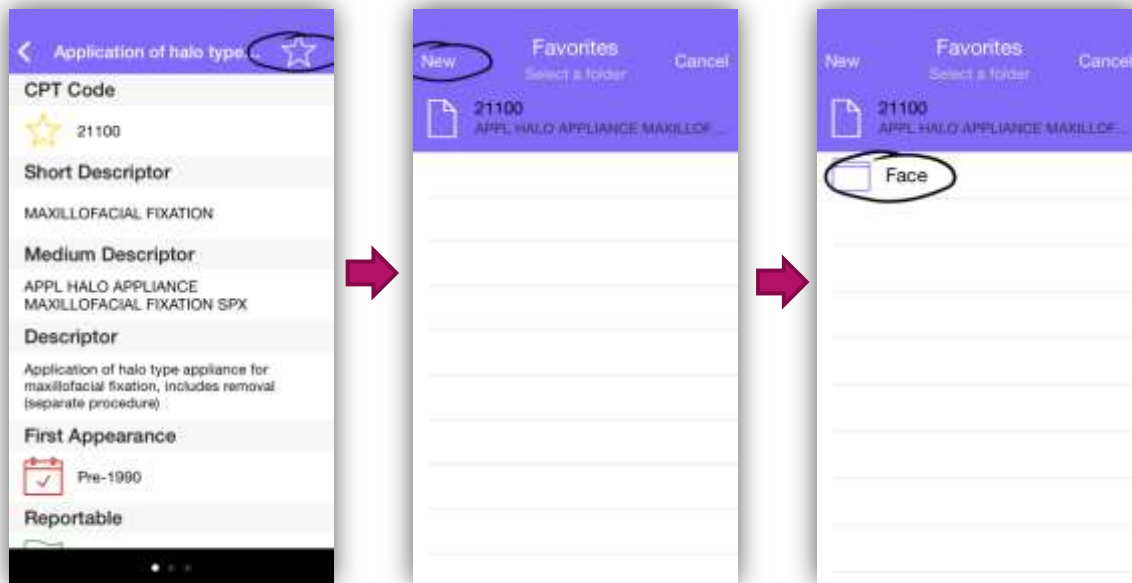
Go to the details screen of the code, either using the categories or searching for the code and then tapping it on the results.

Once you are in the details screen of the code, you will see a white star at the upper right corner of your screen, tapping this star will display the Favorites screen.

On the favorites screen you will be prompted to select a folder to place the favorite in, if you don't see any folders you can create one by using the 'New' button on the left upper corner. Once created you will see the new folder on the list.

To complete the adding of the favorite, simply tap the folder and it will be added to it.

## Can a code be on more than one folder?

Yes, you can add a code to more than one folder, when you enter the favorite screen you will see a checkmark on the folders where the code already exists.

What types of folders can I have?

There are different folders for CPT and ICD codes, so all ICD9 and ICD10 codes will share folders while CPT codes will have their own independent folders.

How can I delete a folder?

You can delete a folder by going to the favorites screen and using the 'Edit' button found on the upper right side of the screen. Once you tap this button, you will see a red button to the left of all folders, tapping it will remove the folder and delete all favorite records on that folder.
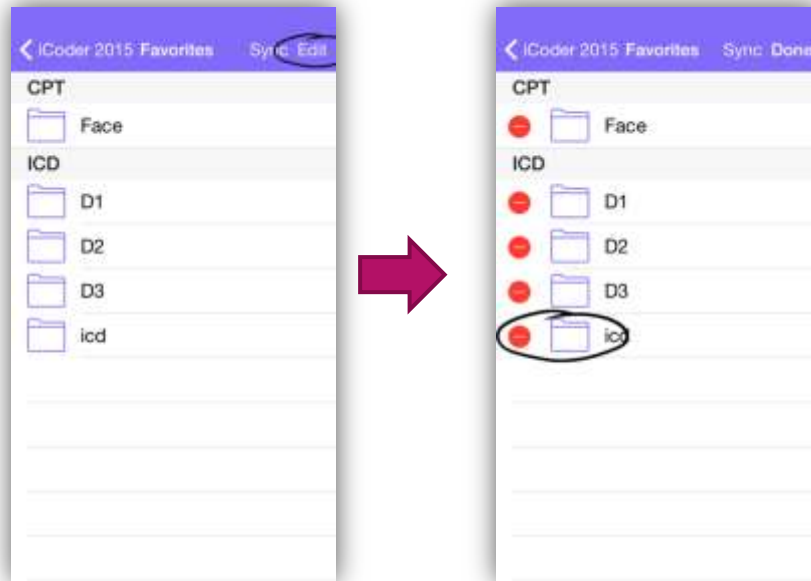
How do I rename a folder?

To rename a folder, go to your favorites screen, tap the folder you want to rename and then use the PEN button found to the left of the Edit button on the upper right side of the screen. Tapping this button will prompt you for the new name for the folder.
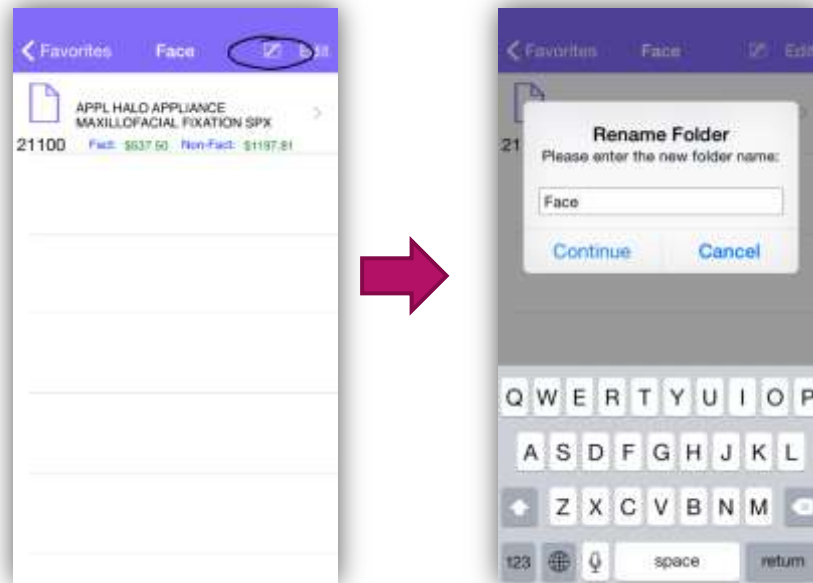
How do I remove a code from a folder?

To remove a code from a folder, go to your favorites screen, tap the folder where your code is and then use the 'Edit' button on the upper right side corner of the screen. You will then see a red button to the left of all codes, tapping this button will remove the code from that folder. The code will remain on any other folder were it is found. Note that you can also swipe left on any code to see the delete button and remove the code from the folder.

How do I make sure I don't lose my favorites?

To make sure you don't lose your favorites, you can save them to the cloud. Please see iCloud Synchronization below for instructions on how to do this.

iCloud Backup

What is iCloud?

iCloud gives you access to your music, photos, contacts, calendars, documents, and more from your Mac, iPhone, iPad, iPod touch, and Windows computer. iCloud stores your content and automatically keeps it up to date on all your devices.

What is iCoder iCloud Backup?

iCloud backup allows you to upload all of your favorites to your iCloud account. Once they are there, you can retrieve them easily, even if you lose your device, your device is erased or you delete the application.

To setup iCloud backup for iCoder, first make sure that you have iCloud enabled, to do this go to your settings screen as shown here:
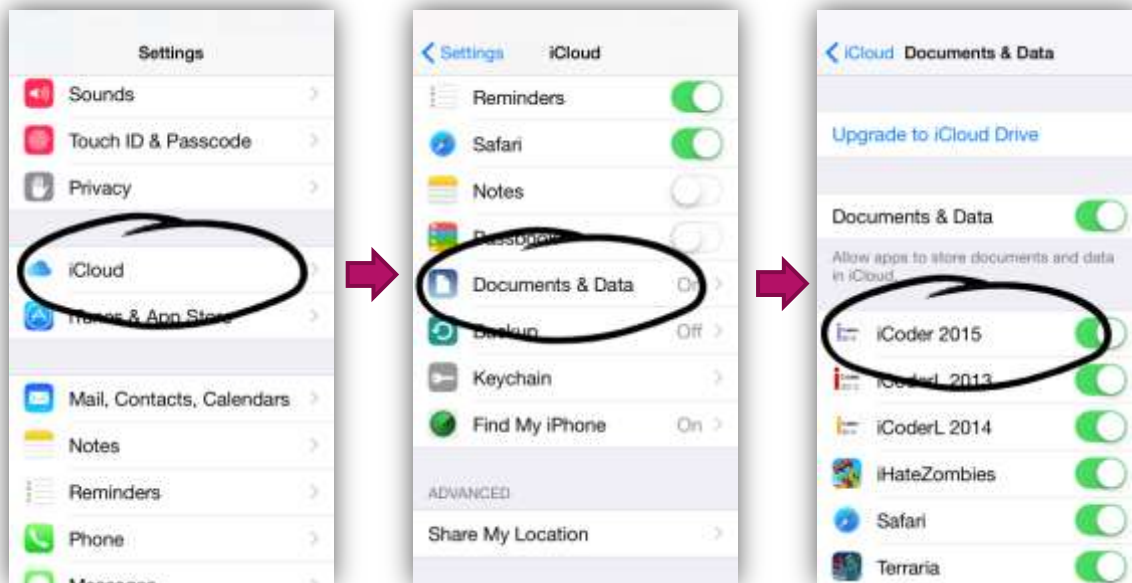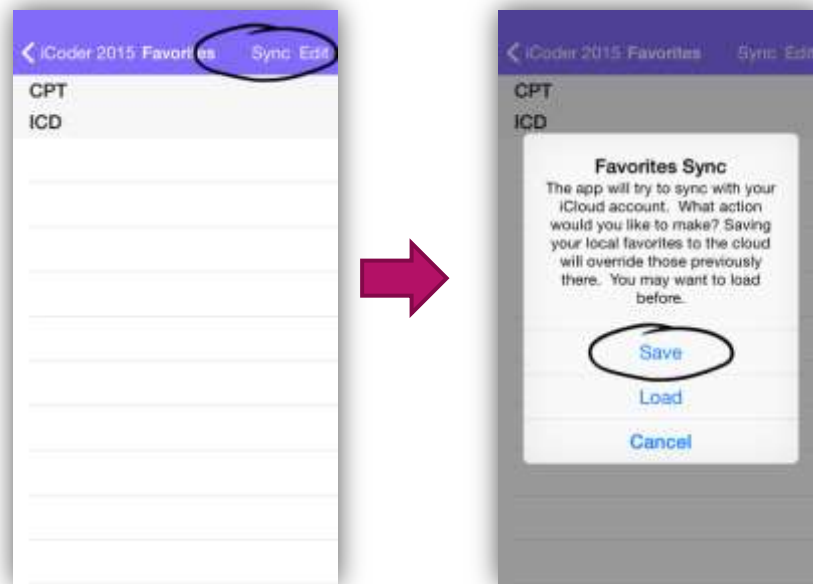

Figure 1- Verifying iCloud Settings

After this, go to your favorites screen and use the Sync button found on the right upper side of the screen:

To load your favorites use the same process but using the Load button.

Can I transfer my favorites from one version of iCoder say 2016 to 2017?

The backup process can be used across iCoder applications, so yes you can backup in iCoder 2016 and restore on iCoder 2017.

Will my nicknames be saved on the backup?

No, nicknames cannot currently be backed up, this is a limitation that we're working with for a future update of iCoder.

Registration

Registration allows you to join our mailing list.

Why should I register?

When you register with iCoder, we will add you to our mailing list and notify you of any news associated with iCoder, such as updates, changes or new features.

We will not give your email address to anyone and we will never send you spam.

Do I need to register to use the iCloud feature?

No, registration is optional and is not required to use any features of iCoder.

Feedback

The feedback option allows you to send us feedback for the app. You can either use feedback button or you shake your device on the screen where you found a problem or want to provide feedback.

Feedback is available on the app's main menu beginning with iCoder 2016. For older versions you can send all feedback to softwaresupport@starinix.com.

There are two types of feedback:

- A bug: A bug is a problem with the app, as such we would like to get a screenshot if possible and a pointer to where the error is, you can easily do that by shaking your device on any screen and selecting 'Report a bug', you will be allowed to draw on the area were the problem is and type a description and your email.
- General Feedback: We are always open to improve the app, and your feedback is crucial for this. To send us feedback you can either use the option on the main menu or shake your device and select 'Send Feedback'. Be sure to include your email so we can ask for more information about your request if we need to.