September – October 2015

# NCDS update

*A Billing Industry Newsletter for Clients*

**Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication…**

## How Will My Practice Benefit from ICD-10?

ICD-10 will provide an enhanced platform for physician practice. As of October 1, 2015, the ICD-10 coding classification will become the new baseline for clinical data, clinical documentation, claims processing, and public health reporting. Understanding patient encounters and preparing for the transition will be critical to the financial sustainability of each practice.

From proper observation and documentation to improved clinical documentation, progress notes, operative reports, and histories, the benefits of ICD-10 begin with enhanced clinical documentation enabling physicians to better capture patient visit details and lead to better care coordination and health outcomes.

Ultimately, better data paves the way for enhanced quality and greater effectiveness of patient care and safety. While the transition to ICD-10 will require work, it is temporary. The benefits of ICD-10 will impact everything from patient care to each practice's bottom line.

"ICD-9 may have been adequate for the past environment, but that's not the environment of the future. ICD-10 is needed to help us paint the picture of the population we are managing in the future payment models. ICD-10 will also allow other physicians and physician extenders to see what took place in the visit." Maggie Gaglione, M.D., Internal Medicine and Bariatrics

**For more information on this article or ICD-10 benefits please visit: http://www.roadto10.org/icd-10-benefits/**

## CMS Road To 10:

Looking for a comprehensive resource for ICD-10 information, handouts, planning tools and more? Roadto10.org brings you all of this information and more, with FAQs, videos, webcasts and interactive case studies. CMS has prepared this page to help providers and practices prepare for the implementation of ICD-10. It contains valuable information for you and your staff to get you up to speed on the October 1, 2015 implementation date.

## Did You Know?...

The United States is approximately thirteen years behind the rest of the world when it comes to the diagnostic coding system. ICD-10 was implemented in most other countries in 2002, so this change is important to bring the United States up to speed with the rest of the medical world.

## ICD-10: 26 Tips You Absolutely Want to Know!

**Betsy Nicoletti, MS – MedScape.com**

**A Is for Active Treatment** A is used for active treatment of an injury, not only the initial encounter. Injuries require a seventh character extender in ICD-10 that defines the episode of care and, for fractures, the healing status of the fracture.

**Causes of Injury** How did the patient get hurt? What was the cause of the injury?

**D: The Seventh Character Extender for Subsequent Trauma Care** The letter D is a seventh character extender for diagnosis codes from Chapter 19, "Injury, poisoning and certain other consequences of external causes."

**Good Grief! (F43.21)** For mental health there's a notation at the start of the intellectual disabilities category that states, "Code first any associated physical or developmental disorders." Substance-abuse codes are expanded greatly in ICD-10.

**History of a Condition** In the index, the history codes are divided into family history and personal history. The family history codes are in categories Z80 to Z84 and include neoplasms, heart disease, nervous system disorders, mental health disorders, digestive disorders, and other conditions.

**Injuries Are Going to Hurt** The largest expansion in ICD-10, these codes make up over 50% of all ICD-10 codes.

**Joints, Bones, and Muscles** Chapter 13, "Diseases of the musculoskeletal system and connective tissue," is the chapter in which we find conditions related to joints, bones, and muscles. A current, acute injury should be coded from Chapter 19.

**Location** Clinicians may find that their coders are asking them for more detail.

**Mapping** Some mapped codes were essentially mapped automatically while others were cross walked by a knowledgeable human being.

**Obstetric Coding** Some codes in this chapter are defined by trimester—a new feature of ICD-10. Also, there's a note to use an additional code from the final chapter category Z3A to identify the specific week of the pregnancy.

**Perinatal Coding** Codes for newborn conditions are in Chapter 16, "Certain conditions originating in the perinatal period," and conveniently start with the letter P.

**Sequela** This seventh character extender is used only to describe the long-term after-effects of an injury or poisoning.

**Table of Drugs and Chemicals** The table of drugs and chemicals has new headings for poisoning and a new column and concept of underdosing.

**X-ray Abnormalities and Other Abnormal Diagnostic Test Results** Codes for abnormal findings on diagnostic tests are found in Chapter 18, "Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified."

**To read the full A – Z article in its entirety please visit: http://www.medscape.com/viewarticle/850992**

# Why You Should Care About the New Major Changes in Medical Billing

**Dina Fine Maron – ScientificAmerican.com**

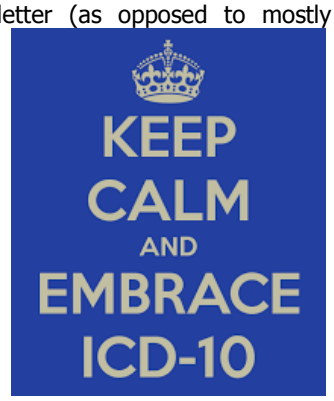
It was only about 10 minutes into the game when I fell on the soccer pitch this summer and tore a ligament in my knee. My subsequent trip to the hospital garnered me a specific diagnostic code that went to my insurance company. My insurer was then able to see why I sought care and billed accordingly. Despite significant upgrades in medical knowledge and care, the same thing would have happened a decade ago. Those codes have remained largely unchanged for more than 30 years. But soon a big change to that collection of numbers and letters may be making a splash—and should bode well for consumers.

Come October 1 a code update will go into effect that will take the current 19,000 diagnostic and procedure codes and catapult that number to 142,000. The transition promises to offer greater granularity to why we seek care. It gets wonky, but with the change researchers that deal in health data might gain more insight into what types of care get good results. That know-how could then trickle down into better care for you. Soon, instead of a code that simply indicates "torn anterior cruciate ligament" there will be separate codes that directly correspond to whether I tore the ACL in my right knee versus my left. Was it my first visit for care for this injury? The new coding system will cover that, too. Under the new system one code will indicate I tore my left ACL and this was my first visit for care. That larger compendium of choices will provide greater specificity for my doctor's future reference and also for insurers trying to suss out whether my care was necessary. Yet one of the most significant aspects of this change continues to go largely ignored by medical workers bracing for rejected insurance claims and frustrations next month: More detailed medical billing codes could eventually improve your health care. Those new codes could provide a clearer picture of why individuals seek care and which health problems are growing or contracting in communities —helping inform what health issues should be researched and improved. At least, that's the hope.

At the same time, some clinicians anticipate serious headaches as insurance companies and medical providers adjust to the new system—called the *International Classification of Diseases* (*ICD-10)*. It is dizzyingly complex. Compared with the 15,000 diagnostic codes in the current system there will now be 70,000. The number of codes for inpatient hospital procedures—now totaling in at 4,000—will spike to 72,000. Many of the codes will not be needed on a regular basis (like V97.33CD, which indicates you were sucked into a jet engine, and this is your subsequent visit to a doctor). "The average internist probably won't need more than 40 to 50 ICD codes for diagnosis," says William Rogers, the ICD-10 Ombudsman for the Centers for Medicare & Medicaid Services (CMS) and a practicing emergency physician at Georgetown University Hospital. But officials overseeing the transition at hospitals and the doctor's office are expecting a significant learning curve. "Other countries have said coders have become very confident in their coding probably within six weeks to six months," says Lynne Thomas Gordon, CEO of the American Health Information Management Association.

In anticipation of these difficulties, CMS announced that during the first year of this new policy they will not reject valid insurance claims as long as health claims were in the right ballpark. That means if you coded for heart failure but did not click the most specific code for "heart failure" the physician will still get paid (or the insured patient will still be reimbursed). "The policy says you didn't get the exact right one, but you got the right category," says Pat Brooks, a senior technical advisor for CMS.

Next month, complications at rollout are expected to match the scale of concerns about Y2K, according to Lisa Iezzoni, director of the Mongan Institute for Health Policy at Massachusetts General Hospital. "I think it will be akin to the concerns with the millennium because we are talking about new alphanumeric systems," she says. For ICD-10, computer systems needed to be altered to accept billing codes that might begin with any letter (as opposed to mostly numbers)—and it's a big change, she adds. In the end, however, "the millennium happened without a whimper and I think that will happen here as well."




The codes actually represent a U.S.-specific tweak of the ICD, a set of World Health Organization categories used internationally to record causes of death. The current U.S. codes classify types of sickness or procedures and largely adhere to the state of medical knowledge circa 1975—which is another reason it is time for a change. Every other industrialized country has already made the transition, Gordon says, including Iceland and Australia. "We didn't have any code to monitor Ebola. I think it was embarrassing for our country but now we will catch up with everybody," she says. Over the years, "hundreds" of small changes occurred on an ad hoc basis when physicians requested them, says Nelly Leon-Chisen, the director of coding and classification at the American Hospital Association, a group that helps educate hospitals on how to use the codes. New codes distinguishing the types of skin cancer were added, for example. But for diagnoses the codes only had so many numerical options before running up against another category of disease so there was an artificial cap on what could be added.

For researchers, the new system will offer the difference between "knowing there are apples in the supermarket and if there are Granny Smith apples versus McIntosh apples," Gordon says. Some medical examples: the new codes will specify what trimester of pregnancy a patient is in when she seeks care. When it comes to orthopedics there is also more detail about which particular bones or tendons are affected.

The promise of gleaning data from these codes is greater than with electronic medical records. Those patient records usually differ across health care settings so there is often no easy way to combine them and extract health data. These medical billing codes, by contrast, will be uniform across the nation. "It's true you can look at a paper record or electronic medical record, but it takes a whole lot of time," Brooks says. "If you have nationally reported codes, you are talking about a simple program with trend analysis with thousands of patients." Right now, even with the less precise codes, the codes help drive research on the quality, cost, accessibility and outcomes of health services. They also help identify trends in care. Will better codes eventually lead to better health? That's what researchers are counting on. After all, the changes are what the doctor ordered.

**For more information on this article please visit:**
**http://www.scientificamerican.com/article/why-you-should-care-about-the-new-major-changes-in-medical-billing/**

**NCDS Perspective:** This is a great article for anyone that is completely unfamiliar with ICD-10 or why it is important. In a simple and basic way it breaks down the complexities of the ICD-10 transition and why it is an important transition in the United States. This close to implementation we would like to think that everyone is ready, knowledgeable and prepared, but that isn't always the reality with so many other major hurdles facing providers. This article emphasizes the reasons for implementing this change, as well as the potential problems and the eventual outcome it seeks to achieve.

# CareSource Retro-Authorizations

**Jessica Meyers – NCDS Medical Billing**

Many providers are met with ongoing denials from CareSource for authorization. If you are an out of network provider that has seen a CareSource patient there are necessary steps you must take to obtain retro-authorization to try to ensure you get paid for your service rendered. From CareSource's provider manual please follow the steps outlined below:

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. **In the event that you fail to obtain prior authorization, you will have 180 days from the date of service, date of discharge, or 90 days from the other carrier's EOB (whichever is later).**

Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service, date of discharge, or date of denial if service was not yet rendered.

Please note: If you are appealing on our member's behalf with their written consent, you have up to 90 days to request the appeal from date of service, discharge date or date of the denial if the service is not yet rendered (whichever is later).

A request for retrospective review can be made by contacting the Medical Management Department at 1-800-488-0134 and following the appropriate menu prompts, or by faxing the request to 1-888-527-0016. Clinical information supporting the request for services must accompany the request.

# Aetna Behavioral Health

Below is a list of services requiring precertification or authorization. This applies only to services covered under the member's benefits plan:

• Inpatient admissions • Residential treatment center (RTC) admissions

• Partial hospitalization programs (PHPs) • Intensive outpatient programs (IOPs) • Psychological testing • Neuropsychological testing • Psychiatric home care services

• Outpatient detoxification • Applied behavior analysis (ABA)

How to request precertification/authorization: To get precertification/authorization for mental health, substance abuse or behavioral health services, submit an electronic precertification request on our secure provider website on NaviNet at https://connect.navinet.net. Register for the site at https://connect.navinet.net/enroll. Or you can choose any other website that allows precertification requests from our list at www.aetna.com/provider/vendor. Open Choice and Traditional Choice plans require precertification for inpatient admissions and residential treatment, although they may not have precertification requirements for additional outpatient procedures listed here.

**http://www.aetna.com/healthcare-professionals/assets/documents/bh_precert_list.pdf**

# HIPAA Investigations: How To Protect Your Practice

**Ron Sterling – MedicalEconomics.com**

How you address patient HIPAA issues, as well as the effectiveness of your HIPAA compliance efforts, can reduce your risk of being subjected to an investigation. All it takes is a single complaint to HHS or a breach report filed by your practice to start an investigation. Fortunately, there are steps your practice can take to avoid this.

Filing a HIPAA complaint is quick and easy through HHS' toll-free number or using the agency's paper or online form, and even a dedicated e-mail address. Your HIPAA Notice of Privacy must notify patients of that right as well as the option of filing a complaint with your own privacy officer.

It's important that your practice effectively supports a patient's right to take this step and be responsive to any such complaints. Many practices do not have a HIPAA complaint form easily accessible to patients. Many practice staffers and physicians aren't familiar with the rights of patients to file a complaint.

Make sure your staff knows how to connect the patient with your privacy officer and how the patient can file a complaint outside of the practice. If your complaint process is difficult, your patients may go directly to HHS to trigger an investigation.

If your practice receives a complaint, you should:

- Contact the patient as soon as possible to gather information on the incident and convey your commitment to addressing the situation. The privacy officer should also explain your internal process.
- Keep the patient informed about the status and resolution of the complaint as well as, if necessary, the breach notification.
- Formally notify the patient about your findings and response to his or her complaint. Your response should help the patient understand the situation and your efforts to address any problems and issues. Note that many complaints may not involve a problem but merely a patient's lack of understanding of your HIPAA obligations and their rights.

- Maintain documentation for the practice on the response to the complaint and any remediation effort so as to avoid similar problems in the future.
- Ensure that practice leadership regularly reviews both the status of complaints and the practice's response to them as part of the HIPAA monitoring effort.

Should the patient also file the complaint with HHS, your practice will be able to provide its response, thereby demonstrating your due diligence and HIPAA compliance.

For more information on how Compliance solutions can improve and benefit your practice contact Mick Polo at mickp@ncdsinc.com

**For more information on this article please visit: http://medicaleconomics.modernmedicine.com/medical-economics/news/hipaa-investigations-how-protect-your-practice**

Maximize Your Revenue

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NCDS Medical Billing

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