WCH Bulletin

September, 2015

MENTAL HEALTH FACILITIES NEED CREDENTIALING MORE THAN EVER

October 1st Regulation for OASAS Is In Effect in New York

If you are concerned that your practice is not ready with ICD-10, whether you are our client or not, the WCH team of professionals is here to help you.

WELCOME TO OUR AUTUMN EDITION

INSIDE THIS ISSUE

iSmart EHR

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For more information please **CONTACT US** at **718-934-6714 x 1202** or by e-mail to: nanak@wchsb.com

Mental Health Facilities Need Credentialing More Than Ever.

October 1st Regulation for OASAS Is In Effect

As many of you are aware, OASAS transition to managed care has taken place. As of October 2015, OASAS is bringing all adult services into Medicaid managed care. This project is part of the Medicaid redesign team initiative.

What does it mean for OASAS current clients?

All future payments for services provided after October 1 will be now managed by Medicaid managed care plans. OASAS centers are obligated to enroll with each managed care plan. WCH credentialing team has experience and expertise in this area to help you transition to managed care. since the existence of OASAS managecare, we have helped many centers successfully contract with insurances in NY.

Our recommendation for all OASAS centers that have not converted to managed care, is to do it immediately to avoid any financial problems in the future. Please note that for any new future OASAS facilities, Medicaid enrollment will still be required. Managed care plans will not enroll the facility without Medicaid. Please do not hesitate to contact our Credentialing department.

Our phone number is **718-934-6714 EXT 1202**

IF HAVE QUESTIONS ABOUT MENTAL HEALTH FACILITY ENROLLMENT?

Contact WCH Credentialing Team at 718-934-6714 EXT 1202

EHR redesigned by WCH to make your practice smile again

Can iSmart EHR be any more sophisticated?

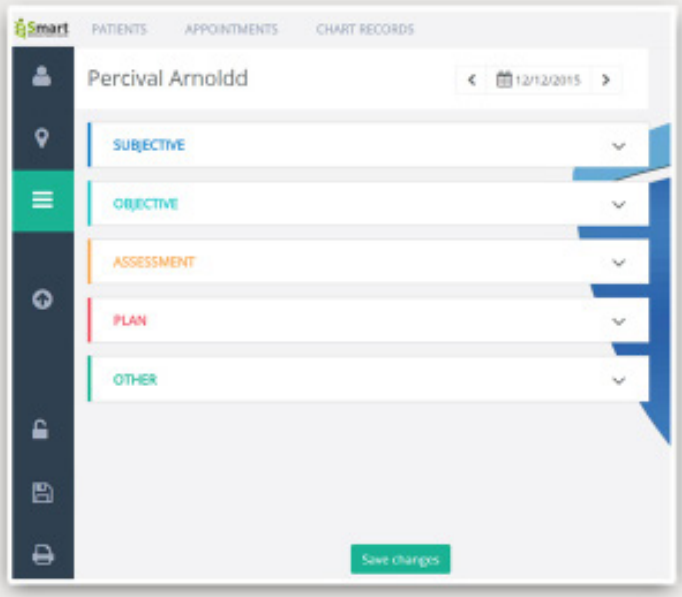
That was the issue; the question which initiated us to understand how to improve our EHR product basing on accumulated knowledge of the matter. And thanks to the feedback and recommendations we have had from our clients we concluded to give priority to 'Chart Record' and 'Template' sections to be improved.

Timeframe

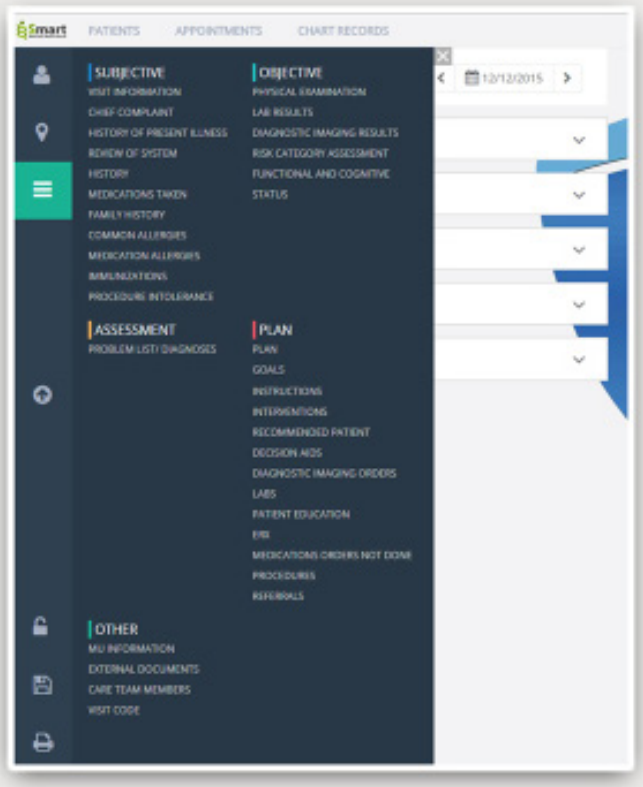
The implementation was started at mid-August and we hope it will have been finalized very soon (by the mid-November).

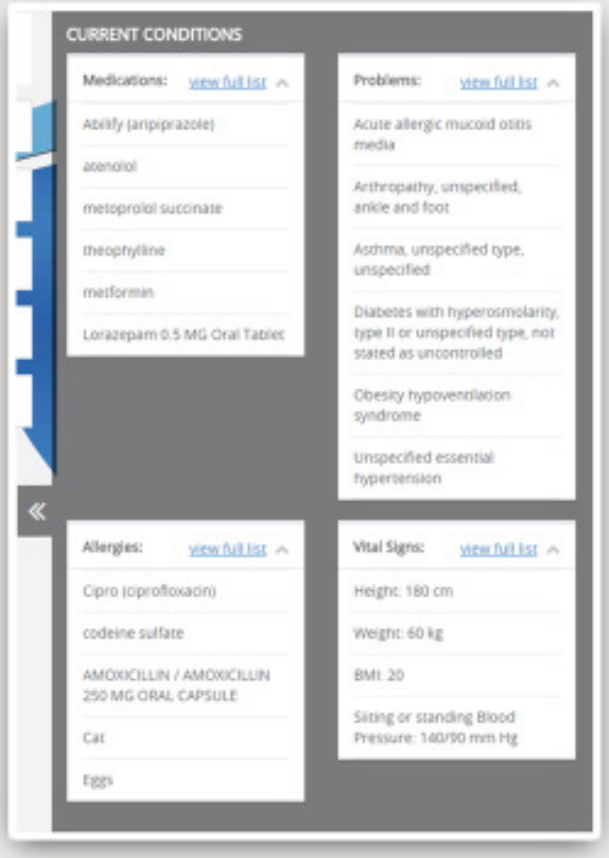
Advanced design

We have redesigned the look of "Chart record" and made differences in sections' colors. Now our clients may easily and quickly find appropriate sections.



The simplest navigation will never make you perplexed.





Only one click to display current conditions of the patient.

New "Template" section. For data structuring nothing is better but simplicity.

Functionality

- Both "Chart record" and "Template" sections are now flexible and easy in customization.
- Informative tips help not to forget to fill in required fields.
- "Meaningful use" tips.
- Main data and its detailed information are separated but can be rapidly linked within one window.

Finally, it would be wrong not to mention all work being proceeded right now to achieve optimization of iSmart EHR, to make 'Chart Record' and 'Template' sections enhanced.
Importantly, new 'Chart Record' allows our clients to perform all operations within one window that, in turn, excludes the need to waste time for each entity loading.
So, we can't wait to launch a MORE fast, MORE optimized, MORE flexible and easily-customizable product.

CONGRATULATIONS TATYANA!

On becoming a supervisor of group II in the billing department.

Tatyana Kantor, CPB

Billing Department supervisor group II

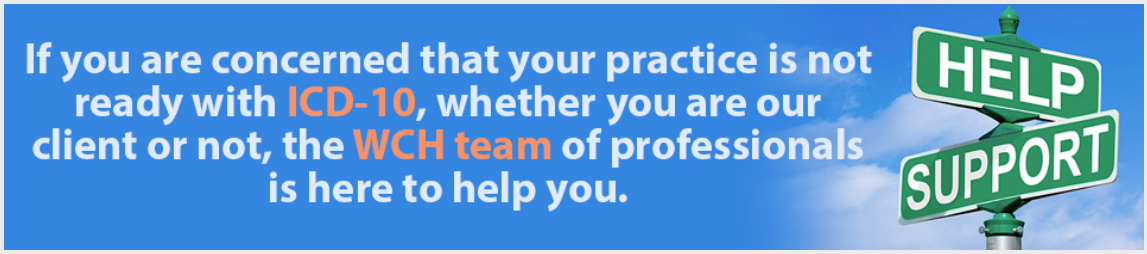
We are pleased to announce the promotion of Tatyana Kantor to supervisor of her billing group. Tatyana is an experienced biller, account representative, and collection specialist. She has been part of the WCH team for four years working directly with clients, insurance companies, and coordinating work within the department. She has been promoted to a supervisor position based on her work ethic and experience.

Once again, congratulations Tatyana on your achievement, we are proud to have you on our team.

ICD-10 is finally here. Over the last year, the WCH team has done tedious work to prepare for the transition to ICD-10. The preparation and testing took place externally as well as internally at WCH. Internally, we held several training modules concentrating on the ICD-10 structure. We reviewed insurance requirements for payment of claims using unspecified codes. We walked all of our clients from ICD-9 to ICD-10 codes, and created templates for each specialty. All of our AAPC coders have completed ICD-10 proficiency assessments. WCH billing and IT department collaboratively designed ICD-10 Electronic Superbills in practice management and EHR ISmart.

Externally, WCH completed testing as a vendor with insurances such as Medicare, Medicaid, Blue Cross, Value Options, and others that were open to testing. Moreover, we tested with associated clearing houses to avoid any unexpected rejections.

We offer ICDF-10 webinars. Please contact your account

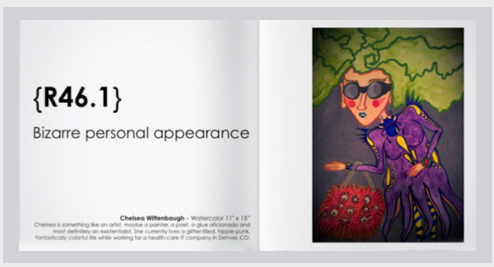


OUR TEAM CAN BE REACHED AT

718-934-6714

OR AT WWW.WCHSB.COM

Bizarre icd-10 code



WHY I LOVE WORKING AT WCH

AN INTERVIEW WITH INNESSA ACCOUNT REPRESENTATIVE

INESSA KHANNOVA
Account Representative

What is your position at WCH?

Explain what you do?

I hold a position of an account representative at WCH Service Bureau. One of my responsibilities is to submit medical claims to insurance carriers. This process is called billing, and its is very important to apply all my knowledge and experience to get maximum reimbursement for providers. I take my responsibilities very serious because I am entrusted with the most important things, such as finances and providers' credentialing. One mistake could cause severe consequences for my company and the client. So, I do my best to follow guidelines and educate myself with new laws and requirements.

What do you like most about working at WCH?

I started working for WCH 9 years ago. It is my first place of employment. This company started me off on this great career. My employers are awesome! They provided me with continuous education and unlimited support in my work and personal life. Also, WCH is a team of great people and friends. It make me want to come to work and do my best.

What are your favorite hobbies and why?

When I have free time, of course I want to have a rest. But I like to cook a delicious dish, salad or a cake, it doesn't matter what I cook. But it should be something tasty and unusual, because I like to please my children with my cooking abilities.

And surely I engage in sports: gymnastic trainings, dances, swimming. I like physical activity and that's why I always try to do sports.

What is most interesting about your job?

Probably, the most interesting thing about my work is that it is always changing. Every day I encounter something new and exciting. I work closely with many amazing people. They make me feel respected and important and this makes me happy.

Bizarre icd-10 code

Famous Doctor in Medicine!

Elizabeth Stern

Early cancer detection

People always hope that if they ever had cancer, that doctors would be able to detect it early so that they can have a higher chance to survive. One of the most deathliest forms of cancer is Cervical cancer. Elizabeth's discovery was a breakthrough in women's health and helped women get the proper treatment that they needed. Even though cancer treatment has a long way to go in terms of fully healing a cancerous patient, Elizabeth's discovery made women around the world have a fighting chance.

Elizabeth Stern was born on September 19, 1915, in Cobalt, Ontario, Canada. She received a medical degree from the University of Toronto in 1939. Stern started working at a Cancer Detection Center where she became interested in cervical cancer. While she was researching, she discovered that cervical cells go through 250 stages as they go from healthy cells to cancerous cells. This helped doctors detect cervical cancer early before it progressed into an advanced stage. This helped cervical cancer become treatable. Before her discovery, it would always be fatal.

Elizabeth Stern could easily be regarded as one of the most influential people in medical history. Without her discovery, many women would not have the proper medicine to treat this deadly form of cancer that has killed so many women.

Source: http://www.biography.com/people/elizabeth-stern-38623#synopsis

Bizarre icd-10 code

WCH EHR offers Anytime, Anywhere Access

Mobility has become one of the main attributes of the efficient EHR. WCH Ismart electronic health record allows providers to have access anytime and anywhere to their clinical and financial data. We highly recommend using EHR on portable technology for access convenience and simplicity of use as opposed to the stationery desktop environment. Of course it's important to consider the size of the screen of the portable device and ability to fit all needed data. Many providers prefer to use laptops over smartphones and tablets, because it has larger screen, comfortable keyboard and full data access with multiscreen capability. Those providers are using the tablets are limited to the data they can see in one screen and are also prohibited to access some of the vital features important for full record documentation.

Because mobility has become an expectation in healthcare it still as important to understand the data access you are getting from your EHR provider on your portable device. WCH can only focus on the features that we present on mobile devices to our clients.

Here is the list of some features easily accessible on mobile EHR:

- Computerized Provider Order Entry (CPOE) and visit information
- Communications
- Encounter documentation
- Patient Chart
- e-Prescribing
- Appointments

WCH Ismart EHR allows you to work from anywhere, anytime - your practice, hospital, secondary office or home.

Inquire about WCH iSmart EHR portable device adaptability by calling our office at 718-934-6714 x 1201

Specialty tailored webinars for your practice

WCH offers training for you and your staff using specialty tailored educational webinars. Webinars are available on topics of interest; you choose the topic or let us train you on today's hottest topics. Our individual webinar or webinar series are designed specifically to provide information to Healthcare Professionals, and Administrative Staff who want to broaden their understanding of healthcare related topics. Our professionally created webinars are administered online with narration by WCH Specialist. The educational webinar is typically an hour long. Slideshows are available upon request.

CEU credits are also offered for participating in the webinars for members that require having for their professional certification. Detailed information about EU credits can be received directly from WCH.

Hot webinar topics to consider:

- ICD 10
- Preventive Medicine
- Most common denials
- Insurance audits
- Available technology that can really help your practice
- Coding
- Credentialing
- Front desk training

Contact us today to request an educational webinar for you and your staff.

Doctors, Are You Speaking with your Billers? Learn Why You Cannot Avoid That Conversation!

Medical billing is the process by which a medical biller converts information about medical service, performed by healthcare provider into appropriate claim format. The duty of the medical biller is to ensure that the provided data is entered accurately, however in WCH the duties of the medical biller go beyond just claim submitting. Our professional medical billers strive to submit a clean claims to payers on behalf of the clients. This should be achieved not only with our staff knowledge, but also requires close and consistent communication between healthcare provider and billing staff. It's an obligation of healthcare provider to monitor the process of medical billing.

We strongly advise our clients to conduct regular meetings with their account representatives in WCH.

- Compliance governing organizations such as OMIG and OIG state that communication between providers and billers is a requirement. OIG Policy states that practices must create a mechanism for the billing staff to communicate effectively and accurately with the health care provider. Regular involvement and communication between providers and billers serves to prevent fraud and increase practice compliance.
- Regular communication between providers and billers improves the overall practice reimbursement, compliance as well as accuracy. When discussing the medical services billed, the biller can advise on code assignments to accurately describe the service that was ordered by the physician; the biller can discuss proper coding and ensure that only accurate and properly documented services are billed according to insurance policies.
- Establishing and maintaining a process for denial review results in increased reimbursement. Getting to know the reason for claim denials and how they can be avoided improves revenue levels. The billing representative reviews the entire process from front desk to claim submission and identify reasons for claim denial and correct errors; the close communication prevents the same errors from happening in future claims and saves the provider time and money.
- Communication with billing staff adds a layer of protection to the practice, especially in a multispecialty group. Controlling that proper codes are used and timely documentation of all physician is obtained prior to billing to ensure that only accurate and properly documented services are billed;

WCH has encountered cases in which providers were not communicating enough with the billing staff which resulted in issues that could have been easily avoided.

WE ARE HERE TO HELP YOU! TALK TO US!

New York Medicaid Update

Important Behavioral Health Services Changes Effective October 1, 2015

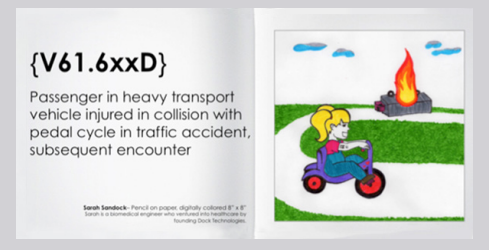
Currently, certain Behavioral Health (BH) benefits are paid Fee for Service (FFS) for managed care enrollees if they meet the condition of Medicaid categorization as SSI or SSI related or for individuals who require services that were previously carved out of Medicaid managed care (MMC). Effective October 1, 2015 Behavioral Health services will be transitioned into the benefit package for Mainstream managed care plans for adults (21 years of age and older) in New York City, requiring these (BH) provider claims be billed to the managed care plan. Commencing July 1, 2016 adults in the Rest of State will transition.

While the State has made many system modifications to support this transition, system configurations continue to be made. Mainly, eligibility verification of NYC Adults will incorrectly respond "Mental Health" carve-out for SSI consumers until all system changes are completed. This response should not deter providers from billing the MMC plans for BH covered services beginning 10/1/15. On 10/1/15, providers are required to bill the MMC plan for these services if provided after the implementation date. Until the system changes are complete, providers in NYC who inappropriately bill Medicaid FFS for BH services for MMC enrollees, may have their claim pay instead of denying. Please note that the Department of Health (DOH) will conduct a review of Behavioral Health FFS payments to identify any incorrect payments made after the BH transition implementation date. All inappropriate payments will be recovered by DOH.

Provider questions should be directed to the Provider Hotline at **1-800-343-9000**.

Link: www.emedny.org

Bizarre icd-10 code



NEW YORK MEDICAID NEWS

Attention Rehabilitation Providers

(Occupational, Physical and Speech Therapy)

New Benefit Year Brings Change to Prior Authorization Requirement

A new benefit year began April 1, 2015 for fee-for-service (FFS) rehabilitation prior authorization (PA) requests. Rehabilitation services (physical, occupational, and speech therapy) have a 20-visit benefit limitation for specific populations. Effective immediately, there is no longer a requirement to obtain the authorization prior to the provision of service. System enhancements were made to the Dispensing Validation System (DVS) to permit provider requests for retroactive PAs.

Medicaid providers must still obtain PAs, but they may now obtain them prior to service, on the day of service, or after the service has been provided. The authorization must be obtained prior to the claim submission to Medicaid and must be included on the claim. This means that if a prior authorization was not obtained prior to the date of service, the provider must request the authorization with the DVS.

- A PA does not guarantee Medicaid payment.
- Medicaid will only pay for 20 therapy visits per therapy type (occupational, physical, and speech) per benefit year for each beneficiary that is not exempt. Additional information may be found in the Rehabilitation Services Manual online at: https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/index.aspx
- If the provider does not verify the eligibility and extent of coverage of each beneficiary each time services are requested, then the provider will risk the possibility of non-reimbursement for services provided as the State cannot compensate a provider for a service rendered to an ineligible person. Eligibility information for the beneficiary must be determined via the Medicaid Eligibility Verification System (MEVS). The MEVS Provider Manual is available online at: http://www.emedny.org/ProviderManuals/AllProviders/index.

CODING SCHIZOPHRENIA: MENTAL HEALTH ASSESSMENTS REQUIRE SPECIFICITY

Written by Kathy Pride, CPC, RHIT, CCS-P, AHIMA-Approved ICD-10-CM/PCS Trainer

EDITOR'S NOTE: *Kathy Pride is continuing her reporting on diseases that have been covered in the national news media as they relate to ICD-10.The recent death of American mathematician and Nobel Prize winner John Forbes Nash, Jr., in partial recovery from schizophrenia, prompted this article.*

Dr. John Forbes Nash Jr., the Nobel Prize-winning mathematician whose work included non-cooperative game theory, tragically died this past week in a car crash at the age of 86. His work and life were the subject of the Academy Award-winning 2001 film "A Beautiful Mind" starring Russell Crowe, which put into focus the stigma associated with schizophrenia. Nash's famed work in math and other fields extended beyond the game theory work that won him the Nobel Prize.

Many of you have likely seen the movie, but what do we coders really know about schizophrenia, and how is it coded in ICD-10-CM? Let's start with this: what is schizophrenia? According to the National Institute of Health, schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history.

People with the disorder may hear voices other people don't hear. They may believe that other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated.

People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking.

Experts think schizophrenia is caused by several factors. The foremost of these factors are genes and environment. Scientists have long known that schizophrenia runs in families. The illness occurs in 1 percent of the general population, but it occurs in 10 percent of people who have a first-degree relative with the disorder, such as a parent, brother, or sister. People who have second-degree relatives (aunts, uncles, grandparents, or cousins) with the disease also develop schizophrenia more often than the general population.

The risk is highest for an identical twin of a person with schizophrenia. He or she has a 40 to 65 percent chance of developing the disorder.

In addition, researchers believe it takes more than genes to cause the disorder. Scientists think interactions between genes and the environment are necessary for schizophrenia to develop.

Many environmental factors may be involved, such as exposure to viruses or malnutrition before birth, problems during birth, and other not-yet-known psychosocial factors.

Schizophrenia is an equal-opportunity disease, as it affects men and women equally, and it occurs at similar rates in all ethnic groups around the world. Symptoms such as hallucinations and delusions usually start between the ages of 16 and 30. Men tend to experience symptoms a little earlier than women. Most of the time, people do not get schizophrenia after age 45. Schizophrenia rarely occurs in children, but awareness of childhood-onset schizophrenia is increasing.

Coding Schizophrenia in ICD-10

Every coder knows that we can only code what is documented. Mental health providers typically do a great job at documenting the elements needed to code to the highest level of specificity, but often our primary care and specialty physicians will list a mental health diagnosis in the patient's assessment and fail to document the specificity needed to code properly, leaving the coder with no choice but to select an unspecified code.

To document and subsequently code schizophrenia in ICD-10-CM, let's first take a look at what is different between ICD-9-CM and ICD-10-CM. In ICD-9-CM, schizophrenia has two classifications. The first classifies the subtype of schizophrenia – these subtypes are categorized as simple, disorganized, catatonic, paranoid, schizophreniform disorder, latent schizophrenia, residual, schizoaffective disorder, and "other" specified type of schizophrenia. The second classification in ICD-9-CM is the acuity: subchronic, chronic, subchronic with acute exacerbation, chronic with acute exacerbation, and in remission.

According to DSM-5, the diagnostic criteria no longer identify subtypes or acuity. Subtypes had been defined by the predominant symptom at the time of evaluation. But these were not helpful to clinicians, because patients' symptoms often changed from one subtype to another and presented overlapping subtype symptoms, which blurred distinc¬tions among the subtypes and decreased their validity. ICD-10-CM eliminated the acuity of schizophrenia; however, it did not eliminate the subtype. Therefore, ICD-10-CM diagnoses codes are not in harmony with DSM-5.

However, ICD-10-CM did update the schizophrenia subtypes from the ICD-9-CM classification. The ICD-10-CM category for schizophrenia (F20) includes the subtypes paranoid, disorganized, catatonic, undifferentiated, residual, and "other."

Schizophrenia Subtypes

ICD-9-CM

- Simple
- Disorganized
- Catatonic
- Paranoid
- Schizophreniform
- Latent
- Residual
- Schizoaffective
- Other

ICD-10-CM

- Paranoid
- Disorganized
- Catatonic
- Undifferentiated
- Residual
- Other

Other new categories in ICD-10-CM previously classified under schizophrenia in ICD-9-CM are the following:

- **F21** – Schizotypal disorder, which includes borderline, latent, prepsychotic, prodromal, pseudoneurotic, and pseudopsychopathic schizophrenia, as well as schizotypal personality disorder
- **F25** – Schizoaffective disorder, which includes bipolar and depressive types

Look for ICD-11 to finally harmonize the schizophrenia codes with DSM-5.

Of course, by the time we get to ICD-11, the psychiatric community will likely have moved on to DSM-6.

CONTACT THE AUTHOR

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COMMENT ON THIS ARTICLE

editor@icd10monitor.com

http://www.icd10monitor.com/enews/item/1427-coding-schizophrenia-mental-health-assessments-require-specificity?utm_source=Real%20Magnet&utm_medium=E-mail&utm_campaign=75933080

INFORMATION SPECIFIC TO ARTICLE 16 CLINICS

Rehabilitation services (physical, occupational, and speech therapy) provided in an Article 16 clinic are carved out of the managed care benefit package. Effective immediately, Article 16 clinic providers no longer need to request manual overrides from OPWDD for the therapy PAs. For dates of service on and after April 1, 2015, Article 16 clinics may now obtain these PAs directly through the DVS, both retroactively and for recipients enrolled in managed care.

Reminders

There has been no change to the requirement that claim(s) contain a unique procedure code modifier for each rehabilitation service. Refer to Table 1 of this article, Rehabilitation Procedure Code Modifiers, for a list of modifiers. The appropriate modifiers are required on all claims for rehabilitation services, including those not requiring PA. Claims that do not contain the appropriate modifier will be denied.

Refer to Table 2 of this article, Authorization Exemptions for a list of enrollees, settings, and circumstances exempt from the PA requirement. Areas where there are no changes, include:

1. 20 – Visit Benefit Limit: The 20-visit limitation on physical therapy, occupational therapy, and speech therapy is a benefit limit and remains in effect for recipients who are not exempt (Table 2) from the PA requirement. There is no means or opportunity to request an approval or an authorization for more than 20 visits to be reimbursed by Medicaid or a health plan.

2. Benefit Year:

- Medicaid FFS Enrollees: For Medicaid FFS enrollees, the twelve-month benefit year begins on April 1st of each year and runs through March 31st of the following year.
- Medicaid Managed Care (MMC) Enrollees: For MMC enrollees, the twelve-month benefit year is a calendar year, beginning January 1st of each year and running through

December 31st of the same year.

3. Requirement to use modifiers: All providers submitting claims or PAs for physical, occupational, and speech therapy must use a procedure code modifier. The modifier identifies the therapy type and provides a mechanism for counting and matching. Without a modifier, the claim will be denied.

4. If a PA is required, it must be included on the claim at the time of submission. If no PA is on the claim and one is required, the claim will be denied.

5. There has been no change to individuals, circumstances, or settings which do not need a PA. They remain exempt from the PA requirement. Refer to Table 2 for a list of exemptions.

6. Failing to obtain rehabilitation therapy PAs, prior to or on the date of service puts the provider's reimbursement at risk. It is important for the provider to know how many of the rehabilitation therapy visits a beneficiary has already used because Medicaid will only pay for 20 therapy visits per therapy type (occupational, physical, and speech) per benefit year for each beneficiary that is not exempt. Additional information may be found in the Rehabilitation Services Manual online at: https://www.emedny.org/ProviderManuals/Rehabilitation-Srvcs/index.aspx.

http://www.health.ny.gov/health_care/medicaid/program/update/2015/sept15_mu.pdf

Questions and Answers

Q: Is there a one-to-one match between ICD-9-CM and ICD-10?

A: According to the Centers for Medicare & Medicaid Services (CMS), there is not a one-to-one match between ICD-9-CM and ICD-10, and there are several reasons for that, including the following.1. In a Skilled Nursing Facility, the physician must perform the initial comprehensive visit

- There are new concepts in ICD-10 that are not present in ICD-9-CM.
- For a small number of codes, there is no matching code in the general equivalence mappings (GEMs).
- There may be multiple ICD-9-CM codes for a single ICD-10 code.
- There may be multiple ICD-10 codes for a single ICD-9-CM code.

Refer to: http://www.panaceainc.com/question-of-the-week/general?utm_source=Real%20Magnet&utm_medium=Email&utm_campaign=82296784

Q: What is the definition for an ICD-10 code to be considered valid?

A: From the question I will proceed under the assumption your office manager is not bound by any contract, nor do you have in place any handbook that applies to her post-employment obligations. With those presumptions in mind, if you are not offering any additional consideration (money/severance) there will not be a fair barter for her to sign anything. All claims with dates of service of October 1, 2015 or later must be submitted with a valid ICD-10 code; ICD-9 codes will no longer be accepted for these dates of service. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, if a valid ICD-10 code from the right family (see question 5) is submitted, Medicare fee-for-service will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in more detail in Questions 6 & 7. An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:' C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site

C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes

C81.10 Nodular sclerosis classical Hodgkin lymphoma, unspecified site

C81.90 Hodgkin lymphoma, unspecified, unspecified site

During the 12 months after ICD-10 implementation, using any one of the valid codes for Hodgkin's lymphoma (C81.00, C81.03, C81.10 or C81.90) would not be cause for an audit under the recently announced flexibilities. In another example, a patient has a diagnosis of G43.711

(Chronic migraine without aura) or G43.719 (Chronic migraine without aura, intractable without status migrainosus) instead of the correct code, G43.711, would not be cause for an audit under the audit flexibilities occurring for 12 months after ICD-10 implementation, since they are all in the same family of codes.

Many people use the terms "billable codes" and "valid codes" interchangeably. A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether an additional 4th, 5th, 6th or 7th character is needed. Using this free list of valid codes is straightforward. Providers can practice identifying and using valid codes as part of acknowledgement testing with Medicare, available through September 30, 2015. For more information about acknowledgement testing, contact your Medicare Administrative Contractor, and review the Medicare Learning Network articles on testing, such as SE1501.

www.panaceainc.com

Q: Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

A: In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf

Q: Are there any resources/support for providers?disclosing my participating status

A: Yes, CMS has published provider training materials - https://www.cms.gov/medicare/coding/icd10/providerresources.html

Q: I'm in the process of a RAC Medicare Audit. How is what CMS is doing legal? How can they request this many charts? How can they question my medical decision making? How can they start earning interest and make me wait years for a result? What kind of system is this?

Not trying to sound accusatory in my questions, but can you shed some light? How can they be stopped? What can I do to help?

A: Dr. P, I wrestle with these questions constantly. How can members of Congress, patients themselves, have passed legislation authorizing the criminal and overreaching authority of the RACs? Well, they did. And for years now, YEARS!, practitioners have been subject to downright abuse. The sheer volume of records requested, the lack of ability to speak with a human being in the review process, the lack of compromise and finality of determinations, the pay structure to the auditors (they receive a percentage of the money they recoup back as payment), the interest accruing, and that's just the overpayment audits! We did not even get to the prepayment reviews!

Its any wonder anyone still remains a par doc in the Medicare system!!!

So, what can you do? You elect to take Medicare and right now Medicare is legally authorized, with the judiciary system assistance (the ALJ program as the third stage of review) to violate practitioners and their ability to practice with such disruption. You have 3 options - 1. drop out. 2. fight city hall on your own. 3. support organizations collating support to fix things through the legislature.

One such group is the American Hospital Association. Currently legislation supported by the AHA is pending that is aimed to:

- *Eliminate the contingency fee structure; instead, it would pay RACs a flat fee, as every other Medicare contractor is paid, to reduce the financial incentive for overzealous auditing practices.*
- *Reduce payments to RACs that are inaccurate in their audit determinations and have high appeals overturn rates.*
- *Fix the Centers for Medicare & Medicaid Services' unfair rebilling rules by allowing hospitals to rebill claims when appropriate.*
- *Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient, not information that becomes available after the patient leaves the hospital.*
- http://www.aha.org/presscenter/pressrel/2015/150501-pr-RAC.shtml

Now, of course, the AHA is Hospital related and Hospital interested. It has been effective, with a limited period of time offered where Hospitals could negotiate down audit dollars and wrap up RAC audits. Individual practitioners have not been offered such an opportunity.

The AMA has been working on limiting RAC rights as well - http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/recovery-audit-contractors.page? but in my opinion less successfully.

My advice - do not sit on the sidelines, get involved. Write to your congressmen/women and lodge complaints, support legislation and push for change.

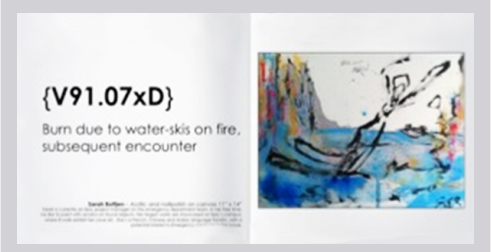
Contact your representatives here -

https://www.opencongress.org/people/zipcodelookup. This is a non-partisan issue. This is a patient issue. These audits are impacting care.

I just have to add, to add insult to injury, in our firm's defense of clients against the RACs, we always highlight to the RACs the Physician Treatment Rule, which was passed by legislation and states deference is to be paid to the treating provider. This statute is disgraced with each RAC audit, where laypersons and lower licensees are flagrantly substituting their judgement for the practitioner under review. I guess that's what we get in our webmd society.

From Jennifer Kirschenbaum

Bizarre icd-10 code



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Thank you!