THE CHENNAI CHAPTER OF AAHAM
American Association of Healthcare Administrative Management

Chennai Connexions

Issue 5, June 2015 www.aahamchennai.org | e-Newsletter

What can you find in this edition?

Editorial

We are glad to bring the next edition of Chennai Connexions to you. We intend to use this as a tool to connect with all our members.

We have tried to cover some of the important updates from the industry that would help our billing offices to perform better, in this edition. We welcome you to contribute articles to the newsletter and share your knowledge and expertise with all the other members.

We hope you would find this edition useful. Happy reading!

Do you have an article for the next edition of Chennai Connexions? Please send it to **secretary@aahamchennai.org**.

-Editorial Team

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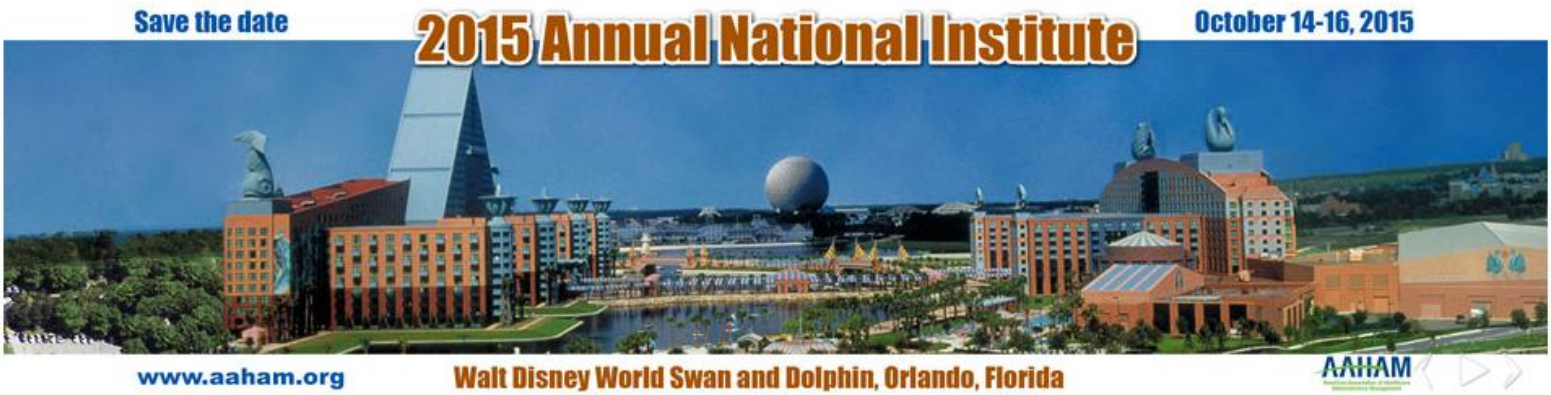
Updates from AAHAM National



Chapter Update!

Congratulations to Gregory Rozario from The Chennai Chapter of AAHAM for scoring the highest in the CRCE - P Exam!

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Importance of ICD 10 CM

By Gregory Rozario

With all the transforms to electronic records the question most frequently asked is, "How important is ICD-10-CM/PCS?"

The undersized response to the question is….."**EXTREMELY VITAL"**.

Transitioning to ICD-10 is a foremost disruption that providers and payers may prefer to evade. But it is an upgrade long overdue, and the benefits are far-reaching.

The outcome of this alteration will almost certainly have an effect on cash flow during the transition (shift/move) period, but more so if facilities/providers haven't fully updated their internal processes.

The healthcare industry continues to wait for definitive action; in fact they wait anxiously, because the transform represents an alarming disruption. However, no matter the difficulty, the transition is essential, because the present coding system can't take healthcare into the future. Today's data needs are spectacularly different than they were 30 years ago when ICD-9 was brought in.

Profile of ICD-9-CM vs. ICD-10-CM/PCS

- ICD-9-CM is more than 30 years old, and stands for **International Classification of Disease, 9th revision, Clinical Modification**. The **clinical modification** was an edition of the **World Health Organization's(WHO) ICD-9**. The elementary reason for ICD-9 was to collect basic health statistics/ figures. The clinical modification used in the US allows for more precise codes to explain the clinical image of the patient than the statistical groupings or trend analysis in ICD-9. Further, the technology used to transmit the clinically coded data has changed significantly from 1979.

  Over the years ICD-9-CM has restricted the medical community in defining their diagnoses as medicine continues to recognize new diagnoses and distinguish current diagnoses. Additional diagnoses are unable to be included to categories in ICD-9-CM due to the numeric structural limitation.

- ICD-10 classification system is the most up-to-date version with its historical origins in the 1850s. ICD-10 was sanctioned by the 43rd World Health Assembly in May 1990 and came into use in WHO Member States as early as 1994. It had been assumed that since USA uses the ICD-9-CM for reimbursement and case mix this was the reason for delays in implementation of ICD-10-CM. However, other countries also use ICD-10 for reimbursement and case mix. For example, the UK has been using it since 1995, most of the rest of Europe by 2000 and Canada by 2001.

Importance of ICD 10 CM (continued...)

By Gregory Rozario

Differences between ICD-9-CM and ICD-10-CM/PCS

There are structural differences between **ICD-9-CM vs. ICD-10-CM** & **ICD-9- PCS vs. ICD-9- PCS** which are outlined in the tables below: 1. **ICD-10-CM** classifies the diagnoses identified in the health care system 2. **ICD-10-PCS** identifies the Procedural Classification System.

Table 1

ICD-9-CM Diagnosis Code Structure	ICD-10-CM Diagnosis Code Structure
Approximately 14,000 codes	Approximately 68,000 codes
3-5 characters in length	3-7 characters in length
First character may be alpha (E & V Only)	First digit is always alpha
2nd - 5th digits are numeric	2nd and 3rd digits are numeric 4th - 7th digits could be alpha or numeric
Lacks detail like laterality	Very specific includes laterality
Limited space for adding new diagnostic codes	Flexibility for adding new codes due to the alpha numeric structure
Data analysis difficult due to non-specific codes for administrative and medical research	Specificity improves coding accuracy and richness of data for administrative analysis and medical research.

Table 2

ICD-9-Procedure Code Structure	ICD-10-Procedure Code Structure
Approximately 3,500 codes	Approximately 72,000 codes
3-4 numeric characters in length	7 alpha-numeric characters in length
Based on outdated terminology and technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexibility for adding new codes
Lacks detail like laterality	Very specific and allows laterality
Lacks description of methodology and approach for procedures	Provides detailed description of methodology and approach for procedures
Generic terms for body parts	Detailed descriptions for body parts
Limits DRG assignment	Allows expansion of DRG definitions to recognize new technologies and devices

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Importance of ICD 10 CM (continued...)

By Gregory Rozario

ICD-10-CM extensively increases the level of clinical detail that can be captured and reported. This table exhibits there is an increase of 4.5 times the number of codes. The other factor is the actual structure of the characters in the length and description by position in the code.

The structural differences for the procedural codes are even more extensive as indicated in the table below:

Whereas, the ICD-10-PCS table reveals an increase of more than 20 times the volume of procedures with more highly structured characters where each digit denotes a specific meaning.

Example of the effect of conversion
In ICD-9-CM only one code exists for angioplasty (procedure for widening a narrowed or obstructed blood vessel). ICD-10 will provide 1170 code descriptions with granularity that pinpoints the location of the blockage and device used for each patient.

Source: http://www.bcbsga.com/shared/noapplication/pressroomwlp/nosecondary/notertiary/pw_e169977.pdf?refer=chpfooter

Medicare Supplement vs. Replacement

By Senthil Kumar K

Medicare Supplements

A supplement is something added to make up for a lack of something else.

Since the inception of HMO/PPO plans, many things have changed in the insurance industry. One of these changes is how we bill Medicare. Traditional Medicare is designed to pay 80% of a claim, and a *supplemental* insurance or the patient covers the other 20%. Recipients will usually pay a second premium to an insurance company to cover that expense. This leaves the patient with a premium for Medicare and a premium for a supplemental insurance. A supplement will always be a secondary payor.

Medicare supplements:

- Follow Medicare
- Pay the 20% of the claim left by Medicare
- Can be any type of insurance

Medicare Replacements

A replacement is something to take the place of something else, or to provide an equivalent for something.

Strict guidelines were developed to allow HMOs/PPOs to sell their insurance to cover 100% of the medical costs. This was the birth of the term, "Medicare Replacement Plan." They are also known as "Medicare Advantage Plans". These replacements cover the 80% Medicare would have paid AND the 20% supplement that would have been left, all in exchange for one small premium.

Medicare replacements:

- Pay at the Medicare fee schedule and the 20% leftover
- Take the place of Medicare insurance
- Need no supplemental insurance
- Delete Medicare from the bill stream
- Indicate somewhere on the card it is Medicare insurance

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Cyber Attack!

By Gregory Rozario

One of the gigantic health plans falls prey to cyber-attack!

People who are employed in the healthcare industry are aware of the importance of protecting health information entrusted to them. By being aware, it doesn't make the task any easier. In fact, some of the biggest health insurance companies with big bucks to spend on protecting their clients' health information are also defenseless to the attacks of cyber wrongdoers—like Premera Blue Cross. Premera has fallen prey to such attacks, is it true? Yes indeed! Premera Blue Cross has been the target of a sophisticated cyber-attack. Premera, a Pacific Northwest health insurer of the Blue Cross Blues Shield association announced that they had fallen prey to a cyber-attack on January 29 of this year(2015).

According to the report, more than 11 million people may possibly be affected by the cyber-attack, which could have exposed the individual's personal information (such as social security number, bank account information, mailing addresses etc). Premera stated that the cyber criminals gained access to their systems on May 5 of last year(2014), adding that it did not discover the breach until January 29 of this year(2015).

As required by law, a breach of this enormity must be brought to the notice of the secretary of Health and Human Services, and the breach will be posted online by the secretary. When you log in to the HHS Office of Civil Rights breach portal, you'll notice that there have been more than 1,100 reported data breaches involving 500 or more individuals since launching the website in 2009. Premera also stated that it did not find proof of data being taken from its systems, or that any member's information has been incongruously used. Despite that, it is offering affected members two years of credit monitoring and identity theft security, free of charge. The breach is currently under investigation. The FBI and cyber-security firm are working with Premera to detect the source of the attack, while also making some repairs to its systems.

Unfortunately, Premera is not the only health insurer to fall victim to a cyber-attack. Anthem revealed in February of this year(2015) that it, too, was the victim of a cyber-attack. Anthem reported a security breach of more than 78 million individuals' personal health information.

Barack Obama has declared new measures designed to combat cyber-attacks. Large corporations have the financial resources to triumph over cyber-attacks, but most small physician offices do not. Even private practices are at threat for data breaches. President Barack Obama ordered a new sanctions program on Wednesday, April 1st 2015 which could block assets of US, and foreign hackers and of businesses that seek to profit from cyber-attacks. Obama stated that the risk from cyber-attacks was a "national emergency", and the new sanctions could assist in fighting back against those implicated in the attacks on US targets.

"Starting today, we're giving notice to those who pose significant threats to our security or economy by damaging our critical infrastructure, disrupting or hijacking our computer networks, or stealing the trade secrets of American companies or the personal information of American citizens for profit," Obama said in a blog post released by the White House.

The pronouncement comes in the midst of an outbreak of incidents registered in the recent months, including an alarming attack on data breaches that stole credit card or health data of tens of millions of Americans.

Under the order, the US Treasury will be able to prevent assets of those implicated in the attacks on "critical" US computer networks, such as banking systems, or the theft of data such as credit card details, and of companies that profit from such attacks.

Source: http://fortune.com/2015/03/17/premera-blue-cross-hacking-breach/

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CPT Additional Codes and Changes

By Kiran Kumar P

Source: Parts of this article is taken from the Current Procedural Terminology.

	NEW CODES	UPDATES ON DESCRIPTION	DELETED CODES
Social History	Military history has been added as one of SH		
Neonatal		99468 to 99476 = Pediactric CCT for neonates are per day codes based upon the age of the baby. Initial CCT can only be reported once per hospital stay even if the patient regresses back to CCT	
	99184 - initiation of selective head or total body hypothermia in the CCT neonate		
Possible for Office Visits	99490	99487 and 99489	
ER and Hospitalist	99497 - advance care planning including the explanation and discussion of advance directives; first 30 minutes, F2F with the patient, family member(s) and or surrogate		
	99498 - each additional 30 minutes, must be used with 99497		
	Note: these codes may be reported on the same day as an E/M, but not with CCT or ICU		

CPT Additional Codes and Changes (continued...)

By Kiran Kumar P

	NEW CODES	UPDATES ON DESCRIPTION	DELETED CODES
Musculoskeletal			
Arthrocentesis		20600 - arthrocentesis or injection of small joint or bursa (ex: fingers, toes); w/o US	
	20604 - with US		
		20605 - arthrocentesis of injection of intermediate joint or bursa (ex: wrist, elbow); without US	
	20606 - with US		
		20610 - arthrocentesis or injection of major joint or bursa (ex: hip, knee); without US	
	20611 - with US		
		Note: Do not report a separate US (76942) with any of these codes	
		Do not report 27320 (inj of contrast for knee arthrography) with arthrocentesis of major joint(20610 and 20611)	
Rib Fractures			
	21810 - treatment of rib fracture requiring external fixation (flail chest); use 21899, unlisted procedure, neck or thorax		21800 - closed treatment of rib fracture, uncomplicated.
			simply report the appropriate level of E/M

CPT Additional Codes and Changes (continued...)

By Kiran Kumar P

	NEW CODES	UPDATES ON DESCRIPTION	DELETED CODES
Radiology			
	New codes 76641 & 76642 can only be reported one per breast, per session; can only be reported with thorough evaluation of the organ(s)/anatomic regions, with image documentation and final written report. Replaces deleted codes 76645		76645
	76641 - US breast, unilateral, real time with image documentation, including axilla when performed; complete (consists of all 4 quadrants and retroareolar region and axilla when performed)		
	76642 - US breast, unlilateral, real time with image documentation, including axilla when performed; limited		
	assigned when less than all elements for 76641 are performed		
	also includes the axilla when performed		
Wound Care			
		97605 - negative pressure wound therapy utilizing DME, including topical applications, per session; less than or equal to 50 SQ CM	
		97606 - greater than 50 SQ CM	
	97607 - negative wound pressure wound therapy utilizing disposable, non durable medical equipment; less than or equal to 50 SQ CM		
	97608 - greater than 50 SQ CM		

CPT Additional Codes and Changes (continued...)

By Kiran Kumar P

	NEW CODES	UPDATES ON DESCRIPTION	DELETED CODES
Facility			
vaccines/toxoid			
	90651 - human papillomavirus vaccine		
		90654 - influenza virus, trivalent	
		90630 - influenza virus, quadrivalent	
		90721 - diptheria, tetanus and accellular pertussis and H influenza B (DtaP/Hib)	
		90723 - diptheria, tetanus, acellular pertussis, hepatitis B and poliovirus	
		90734 - meningococcal conjugate vaccine, quadrivalent	

Billing Terms

By Janarthanan P

Dingy Claims:

It happens when the Insurance cannot process a claim for a particular service or bill type. The claims are held until the necessary system changes are implemented to pay the claim correctly.

Dropped Claims:

These are the claims which are rejected by the Clearing house due to wrong details or lack of information checked during “Preliminary Screening.

Source: www.cram.com

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Use of Modifier 25

By Swaminathan S

Modifier 25 is the most important modifier for pediatricians. Modifier 25 denotes significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service rendered by physician.
Here are some specific requirements for the use of modifier 25:

- The E/M service must be significant. The problem must warrant physician work that is medically necessary. A minor problem would not warrant the billing of an E/M 25 service.
- The E/M service must be separate. The problem must be distinct from the other E/M service provided or the procedure being completed. Separate documentation for the E/M-25 problem is helpful in supporting the use of modifier 25 and especially important to support any necessary denial appeal.
- The E/M service must be provided on the same day as the other procedure or E/M service. This may be at the same encounter or a separate encounter on the same day.
- Modifier 25 should always be attached to the E/M code. If provided with a preventive medicine visit. It should be attached to the established office E/M (99211-99215).
- The separately billed E/M service must meet documentation requirements for the code level selected. It will sometimes be based on time spent counseling and coordinating care for chronic problems.

Source: Parts of this article is taken from the Current Procedural Terminology.

Interested in taking up AAHAM certifications? Visit **http://www.aahamchennai.org** and write to us through the contact us page.