

# TIPS FROM OUR CONSULTANT

By: Joy Newby, LPN, CPC  
Newby Consulting

## ANTHEM UPDATE

### Billing for “Incident to” Services

[http://www.anthem.com/provider/noapplication/f1/s0/t0/pw\\_e171174.pdf?refer=ahpprovider&state=in](http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e171174.pdf?refer=ahpprovider&state=in)

“Incident to” services are provided by non-physicians under direct supervision by the supervising provider that are integral to the care of a patient. “Incident to” services are eligible for separate reimbursement, if separately reported, as if the supervising provider had personally provided the service. The “Incident to” services rendered and billed under the supervising provider must meet Anthem’s definition of medically necessary and be otherwise covered services.

Pursuant to its “Incident to” policy, Anthem requires that the supervising provider must:

- Be physically present in the office suite and immediately available when necessary to provide assistance and direction throughout the evaluation and management visit and/or rendered service
- Stay involved and have an active part in the ongoing care of the patient

### Changes Effective December 1, 2011!!

Anthem does not follow CMS “Incident to” reimbursement rules for any M.D. or non-physician practitioner (NPP). If Anthem provides a Provider Identification Number (PIN) to the specific type of NPP who rendered the services, the **service must be reported using the NPP’s** name and National Provider Identifier (NPI). This rule applies even when a provider is in the process of applying to Anthem for a PIN. If the provider is a type to whom Anthem issues a PIN, then while the provider is waiting to receive a PIN, his/her services are not eligible for reimbursement as “Incident to” services.

Anthem will assign a PIN to the following NPPs:

- Nurse Practitioner
- Clinical Nurse Specialist
- Physician Assistant

The following services are not eligible for reimbursement as “Incident to” services:

- Services rendered by any provider who is eligible, under Anthem policies, to directly submit claims to Anthem for reimbursement, regardless of whether NPP has or has not applied for an NPI or whether an application for an NPI is pending.

Anthem expects those providers currently submitting claims in compliance with its “Incident to” policy to continue that practice. Those providers not already following Anthem’s “Incident to” policy must become compliant on or before December 1, 2011.

If you have any questions, please contact Provider Inquiry or your local Network Relations consultant.

## ICD-9 CODING

### ICD-9 Code Changes Effective October 1, 2011

ICD-9 is updated with the government’s fiscal year which is confusing for some practices as they forget that this means the 2012 ICD-9 codes become effective October 1, 2011. As in past years, practices need to update superbills, cheat sheets, practice management systems, etc. to reflect ICD-9 changes. Physicians using electronic medical records should contact their vendors for information about updating the ICD-9 diagnosis code database. Any personal quick pick or favorite list of diagnosis codes also need to be updated.

The entire list of new, invalid, and revised *ICD-9* codes follows:

### New Diagnosis Codes for 2011

<b>Diagnosis Code</b>	<b>Description</b>
041.41	Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC) O157
041.42	Other specified Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC)
041.43	Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC), unspecified
041.49	Other and unspecified <i>Escherichia coli</i> [ <i>E. coli</i> ]
173.00	Unspecified malignant neoplasm of skin of lip
173.01	Basal cell carcinoma of skin of lip
173.02	Squamous cell carcinoma of skin of lip
173.09	Other specified malignant neoplasm of skin of lip
173.10	Unspecified malignant neoplasm of eyelid, including canthus
173.11	Basal cell carcinoma of eyelid, including canthus
173.12	Squamous cell carcinoma of eyelid, including canthus
173.19	Other specified malignant neoplasm of eyelid, including canthus
173.20	Unspecified malignant neoplasm of skin of ear and external auditory canal
173.21	Basal cell carcinoma of skin of ear and external auditory canal
173.22	Squamous cell carcinoma of skin of ear and external auditory canal
173.29	Other specified malignant neoplasm of skin of ear and external auditory canal
173.30	Unspecified malignant neoplasm of skin of other and unspecified parts of face
173.31	Basal cell carcinoma of skin of other and unspecified parts of face
173.32	Squamous cell carcinoma of skin of other and unspecified parts of face
173.39	Other specified malignant neoplasm of skin of other and unspecified parts of face
173.40	Unspecified malignant neoplasm of scalp and skin of neck
173.41	Basal cell carcinoma of scalp and skin of neck
173.42	Squamous cell carcinoma of scalp and skin of neck
173.49	Other specified malignant neoplasm of scalp and skin of neck
173.50	Unspecified malignant neoplasm of skin of trunk, except scrotum
173.51	Basal cell carcinoma of skin of trunk, except scrotum
173.52	Squamous cell carcinoma of skin of trunk, except scrotum
173.59	Other specified malignant neoplasm of skin of trunk, except scrotum
173.60	Unspecified malignant neoplasm of skin of upper limb, including shoulder
173.61	Basal cell carcinoma of skin of upper limb, including shoulder
173.62	Squamous cell carcinoma of skin of upper limb, including shoulder
173.69	Other specified malignant neoplasm of skin of upper limb, including shoulder
173.70	Unspecified malignant neoplasm of skin of lower limb, including hip
173.71	Basal cell carcinoma of skin of lower limb, including hip
173.72	Squamous cell carcinoma of skin of lower limb, including hip
173.79	Other specified malignant neoplasm of skin of lower limb, including hip
173.80	Unspecified malignant neoplasm of other specified sites of skin
173.81	Basal cell carcinoma of other specified sites of skin
173.82	Squamous cell carcinoma of other specified sites of skin
173.89	Other specified malignant neoplasm of other specified sites of skin
173.90	Unspecified malignant neoplasm of skin, site unspecified
173.91	Basal cell carcinoma of skin, site unspecified
173.92	Squamous cell carcinoma of skin, site unspecified
173.99	Other specified malignant neoplasm of skin, site unspecified
282.40*	Thalassemia, unspecified
282.43*	Alpha thalassemia
282.44*	Beta thalassemia
282.45*	Delta-beta thalassemia

<b>Diagnosis Code</b>	<b>Description</b>
282.46*	Thalassemia minor
282.47*	Hemoglobin E-beta thalassemia
284.11*	Antineoplastic chemotherapy induced pancytopenia
284.12*	Other drug- induced pancytopenia
284.19*	Other pancytopenia
286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
294.20	Dementia, unspecified, without behavioral disturbance
294.21	Dementia, unspecified, with behavioral disturbance
310.81	Pseudobulbar affect
310.89	Other specified nonpsychotic mental disorders following organic brain damage
331.6	Corticobasal degeneration
348.82	Brain death
358.30	Lambert-Eaton syndrome, unspecified
358.31	Lambert-Eaton syndrome in neoplastic disease
358.39	Lambert-Eaton syndrome in other diseases classified elsewhere
365.05	Open angle with borderline findings, high risk
365.06	Primary angle closure without glaucoma damage
365.70	Glaucoma stage, unspecified
365.71	Mild stage glaucoma
365.72	Moderate stage glaucoma
365.73	Severe stage glaucoma
365.74	Indeterminate stage glaucoma
379.27*	Vitreomacular adhesion
414.4*	Coronary atherosclerosis due to calcified coronary lesion
415.13	Saddle embolus of pulmonary artery
425.11*	Hypertrophic obstructive cardiomyopathy
425.18*	Other hypertrophic cardiomyopathy
444.01	Saddle embolus of abdominal aorta
444.09	Other arterial embolism and thrombosis of abdominal aorta
488.81*	Influenza due to identified novel influenza A virus with pneumonia
488.82*	Influenza due to identified novel influenza A virus with other respiratory manifestations
488.89*	Influenza due to identified novel influenza A virus with other manifestations
508.2*	Respiratory conditions due to smoke inhalation
512.2*	Postoperative air leak
512.81*	Primary spontaneous pneumothorax
512.82*	Secondary spontaneous pneumothorax
512.83*	Chronic pneumothorax
512.84*	Other air leak
512.89*	Other pneumothorax
516.30	Idiopathic interstitial pneumonia, not otherwise specified
516.31	Idiopathic pulmonary fibrosis
516.32	Idiopathic non-specific interstitial pneumonitis
516.33*	Acute interstitial pneumonitis
516.34	Respiratory bronchiolitis interstitial lung disease
516.35	Idiopathic lymphoid interstitial pneumonia
516.36	Cryptogenic organizing pneumonia
516.37	Desquamative interstitial pneumonia
516.4	Lymphangiomyomatosis
516.5	Adult pulmonary Langerhans cell histiocytosis

<b>Diagnosis Code</b>	<b>Description</b>
516.61	Neuroendocrine cell hyperplasia of infancy
516.62	Pulmonary interstitial glycogenosis
516.63	Surfactant mutations of the lung
516.64	Alveolar capillary dysplasia with vein misalignment
516.69	Other interstitial lung diseases of childhood
518.51*	Acute respiratory failure following trauma and surgery
518.52*	Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery
518.53*	Acute and chronic respiratory failure following trauma and surgery
539.01	Infection due to gastric band procedure
539.09	Other complications of gastric band procedure
539.81	Infection due to other bariatric procedure
539.89	Other complications of other bariatric procedure
573.5*	Hepatopulmonary syndrome
596.81	Infection of cystostomy
596.82	Mechanical complication of cystostomy
596.83	Other complication of cystostomy
596.89	Other specified disorders of bladder
629.31	Erosion of implanted vaginal mesh and other prosthetic materials to surrounding organ or tissue
629.32	Exposure of implanted vaginal mesh and other prosthetic materials into vagina
631.0	Inappropriate change in quantitative human chorionic gonadotropin (hCG) in early pregnancy
631.8	Other abnormal products of conception
649.81	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with or without mention of antepartum condition
649.82	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with mention of postpartum complication
704.41	Pilar cyst
704.42	Trichilemmal cyst
726.13*	Partial tear of rotator cuff
747.31	Pulmonary artery coarctation and atresia
747.32	Pulmonary arteriovenous malformation
747.39	Other anomalies of pulmonary artery and pulmonary circulation
793.11*	Solitary pulmonary nodule
793.19*	Other nonspecific abnormal finding of lung field
795.51*	Nonspecific reaction to tuberculin skin test without active tuberculosis
795.52*	Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen
808.44	Multiple closed pelvic fractures without disruption of pelvic circle
808.54	Multiple open pelvic fractures without disruption of pelvic circle
996.88	Complications of transplanted organ, stem cell
997.32	Postprocedural aspiration pneumonia
997.41	Retained cholelithiasis following cholecystectomy
997.49	Other digestive system complications
998.00*	Postoperative shock, unspecified
998.01*	Postoperative shock, cardiogenic
998.02*	Postoperative shock, septic
998.09*	Postoperative shock, other
999.32*	Bloodstream infection due to central venous catheter
999.33*	Local infection due to central venous catheter

<b>Diagnosis Code</b>	<b>Description</b>
999.34*	Acute infection following transfusion, infusion, or injection of blood and blood products
999.41	Anaphylactic reaction due to administration of blood and blood products
999.42	Anaphylactic reaction due to vaccination
999.49	Anaphylactic reaction due to other serum
999.51	Other serum reaction due to administration of blood and blood products
999.52	Other serum reaction due to vaccination
999.59	Other serum reaction
V12.21	Personal history of gestational diabetes
V12.29	Personal history of other endocrine, metabolic, and immunity disorders
V12.55	Personal history of pulmonary embolism
V13.81	Personal history of anaphylaxis
V13.89	Personal history of other specified diseases
V19.11	Family history of glaucoma
V19.19	Family history of other specified eye disorder
V23.42	Pregnancy with history of ectopic pregnancy
V23.87	Pregnancy with inconclusive fetal viability
V40.31*	Wandering in diseases classified elsewhere
V40.39*	Other specified behavioral problem
V54.82	Aftercare following explantation of joint prosthesis
V58.68*	Long term (current) use of bisphosphonates
V87.02	Contact with and (suspected) exposure to uranium
V88.21	Acquired absence of hip joint
V88.22	Acquired absence of knee joint
V88.29	Acquired absence of other joint

**Notes:**

\* These diagnosis codes were discussed at the March 9–10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. They will be implemented on October 1, 2011.

**Invalid Diagnosis Codes for 2011**

<b>Diagnosis Code</b>	<b>Description</b>
041.4	Escherichia coli [E. coli] infection in conditions classified elsewhere and of unspecified site
173.0	Other malignant neoplasm of skin of lip
173.1	Other malignant neoplasm of skin of eyelid, including canthus
173.2	Other malignant neoplasm of skin of ear and external auditory canal
173.3	Other malignant neoplasm of skin of other and unspecified parts of face
173.4	Other malignant neoplasm of scalp and skin of neck
173.5	Other malignant neoplasm of skin of trunk, except scrotum
173.6	Other malignant neoplasm of skin of upper limb, including shoulder
173.7	Other malignant neoplasm of skin of lower limb, including hip
173.8	Other malignant neoplasm of other specified sites of skin
173.9	Other malignant neoplasm of skin, site unspecified
284.1*	Pancytopenia
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants
310.8	Other specified nonpsychotic mental disorders following organic brain damage
425.1*	Hypertrophic obstructive cardiomyopathy
444.0	Embolism and thrombosis of abdominal aorta
512.8*	Other spontaneous pneumothorax
516.3	Idiopathic fibrosing alveolitis

<b>Diagnosis Code</b>	<b>Description</b>
518.5*	Pulmonary insufficiency following trauma and surgery
596.8	Other specified disorders of bladder
631	Other abnormal product of conception
718.60*	Unspecified intrapelvic protrusion of acetabulum, site unspecified
747.3	Anomalies of pulmonary artery
793.1*	Nonspecific (abnormal) findings on radiological and other examination of lung field
795.5*	Nonspecific reaction to tuberculin skin test without active tuberculosis
997.4**	Digestive system complications
998.0*	Postoperative shock
999.4	Anaphylactic shock due to serum
999.5**	Other serum reaction
V12.2	Personal history of endocrine, metabolic, and immunity disorders
V13.8	Personal history of other specified diseases
V19.1	Family history of other eye disorders
V40.3*	Other behavioral problems

**Notes:**

- \* These diagnosis codes were discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. They will be deleted on October 1, 2011.
- \*\* The code title has changed from the proposed rule.

**Revised Diagnosis Codes for 2011**

<b>Diagnosis Code</b>	<b>Description</b>
317*	Mild intellectual disabilities
318.0*	Moderate intellectual disabilities
318.1*	Severe intellectual disabilities
318.2*	Profound intellectual disabilities
319*	Unspecified intellectual disabilities
323.41	Other encephalitis and encephalomyelitis due to other infections classified elsewhere
323.42	Other myelitis due to other infections classified elsewhere
346.01	Migraine with aura, with intractable migraine, so stated, without mention of status migrainosus
346.11	Migraine without aura, with intractable migraine, so stated, without mention of status migrainosus
346.21	Variants of migraine, not elsewhere classified, with intractable migraine, so stated, without mention of status migrainosus
346.31	Hemiplegic migraine, with intractable migraine, so stated, without mention of status migrainosus
346.41	Menstrual migraine, with intractable migraine, so stated, without mention of status migrainosus
346.51	Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus
346.61	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus
346.71	Chronic migraine without aura, with intractable migraine, so stated, without mention of status migrainosus
346.81	Other forms of migraine, with intractable migraine, so stated, without mention of status migrainosus
346.91	Migraine, unspecified, with intractable migraine, so stated, without mention of status migrainosus
365.01	Open angle with borderline findings, low risk

<b>Diagnosis Code</b>	<b>Description</b>
488.11*	Influenza due to identified 2009 H1N1 influenza virus with pneumonia
488.12*	Influenza due to identified 2009 H1N1 influenza virus with other respiratory manifestations
488.19*	Influenza due to identified 2009 H1N1 influenza virus with other manifestations
646.70	Liver and biliary tract disorders in pregnancy, unspecified as to episode of care or not applicable
646.71	Liver and biliary tract disorders in pregnancy, delivered, with or without mention of antepartum condition
646.73	Liver and biliary tract disorders in pregnancy, antepartum condition or complication
808.43	Multiple closed pelvic fractures with disruption of pelvic circle
808.53	Multiple open pelvic fractures with disruption of pelvic circle
968.5	Surface (topical) and infiltration anesthetics
995.0	Other anaphylactic reaction
995.60	Anaphylactic reaction due to unspecified food
995.61	Anaphylactic reaction due to peanuts
995.62	Anaphylactic reaction due to crustaceans
995.63	Anaphylactic reaction due to fruits and vegetables
995.64	Anaphylactic reaction due to tree nuts and seeds
995.65	Anaphylactic reaction due to fish
995.66	Anaphylactic reaction due to food additives
995.67	Anaphylactic reaction due to milk products
995.68	Anaphylactic reaction due to eggs
995.69	Anaphylactic reaction due to other specified food
999.31*	Other and unspecified infection due to central venous catheter
V18.4*	Family history of intellectual disabilities
V79.2*	Special screening for intellectual disabilities

**Notes:**

- \* These diagnosis codes were discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. They will be deleted on October 1, 2011.
- \*\* The code title has changed from the proposed rule.

**Have You Been Coding to the Greatest Extent Known?**

In the early 1980s, Medicare began requiring physicians to use *ICD-9* and *CPT* codes on claims. Commercial payers quickly followed Medicare’s lead. Since failure to use valid *ICD-9* codes resulted in denied claims, physicians quickly learned they were required to report the diagnosis code to the highest level of specificity. This continues to mean physicians must follow these guidelines:

- Assign a three-digit codes (known as category codes) only if there are no four-digit codes within the code category.
- Assign a four-digit code (known as subcategory codes) only if there are no five-digit codes for that category.
- Assign a five-digit code (knows as fifth-digit subclassification codes) for that category.

In an attempt to have as many pertinent diagnosis codes as possible on superbills, many practices selected “unspecified” codes to describe services. Some practices have not always coded to “the greatest extent known.” Using clinical judgment and results of any diagnostic tests, physicians should be documenting a complete diagnostic statement in the patient’s medical record and assigning the most specific code available to describe the patient’s problem.

For example, even to this day, some practices continue to report 382.9 for otitis media. Physicians should be selecting the code that better describes the type of otitis media.

381.0 Acute nonsuppurative otitis media

Acute tubotympanic catarrh  
Otitis media, acute or subacute:  
catarrhal  
exudative  
transudative  
with effusion

*Excludes: otitic barotrauma (993.0)*

- 381.00 Acute nonsuppurative otitis media, unspecified
- 381.01 Acute serous otitis media
  - Acute or subacute secretory otitis media
- 381.02 Acute mucoid otitis media
  - Acute or subacute seromucinous otitis media
  - Blue drum syndrome
- 381.03 Acute sanguinous otitis media
- 381.04 Acute allergic serous otitis media
- 381.05 Acute allergic mucoid otitis media
- 381.06 Acute allergic sanguinous otitis media

381.1 Chronic serous otitis media

Chronic tubotympanic catarrh

- 381.10 Chronic serous otitis media, simple or unspecified
- 381.19 Other
  - Serosanguinous chronic otitis media

381.2 Chronic mucoid otitis media

Glue ear

*Excludes: adhesive middle ear disease (385.10-385.19)*

- 381.20 Chronic mucoid otitis media, simple or unspecified
- 381.29 Other
  - Mucosanguinous chronic otitis media

381.3 Other and unspecified chronic nonsuppurative otitis media

Otitis media, chronic:  
allergic  
exudative  
secretory  
seromucinous  
transudative  
with effusion

381.4 Nonsuppurative otitis media, not specified as acute or chronic

Otitis media:  
allergic  
catarrhal  
exudative  
mucoid  
secretory  
seromucinous  
serous  
transudative  
with effusion

382.0 Acute suppurative otitis media

Otitis media, acute:  
necrotizing NOS  
purulent

- 382.00 Acute suppurative otitis media without spontaneous rupture of ear drum
- 382.01 Acute suppurative otitis media with spontaneous rupture of ear drum
- 382.02 Acute suppurative otitis media in diseases classified elsewhere
  - Excludes: postmeasles otitis (055.2)*
  - Code First: underlying disease, as:
    - influenza (487.8)
    - scarlet fever (034.1)
- 382.1 Chronic tubotympanic suppurative otitis media
  - Benign chronic suppurative otitis media (with anterior perforation of ear drum)
  - Chronic tubotympanic disease (with anterior perforation of ear drum)
- 382.2 Chronic atticoantral suppurative otitis media
  - Chronic atticoantral disease (with posterior or superior marginal perforation of ear drum)
  - Persistent mucosal disease (with posterior or superior marginal perforation of ear drum)
- 382.3 Unspecified chronic suppurative otitis media
  - Chronic purulent otitis media
  - Excludes: tuberculous otitis media (017.4)*
- 382.4 Unspecified suppurative otitis media
  - Purulent otitis media NOS
- 382.9 Unspecified otitis media
  - Otitis media:
    - NOS
    - acute NOS
    - chronic NOS

**Plans for ICD-10? Better think about correctly using ICD-9 first!**

Although physicians should have been documenting and coding to the greatest extent known at the time of service, in our experience, the majority of physicians (especially those still using paper charts) have not included specific diagnostic statements in their progress notes. Most physicians have not updated their superbills to allow for selection of the ICD-9 code that best described the patient’s problem because of the desire to keep superbills to one page. In our chart reviews, we find that the diagnostic statements in the patient’s progress note, operative report, diagnostic test interpretation, etc., do not “match” the diagnosis marked on the superbill and included on the claim for the specific date of service.

For physicians, we believe the most challenging part of transitioning to ICD-10 will be the improvement needed in the diagnostic statement(s) in the patient’s progress note. “DM,” “HTN,” “Obesity,” “Conjunctivitis,” etc., are not sufficient for coding to the greatest extent known at the time of service when using ICD-9 codes. The next challenge will be how to create a superbill with enough flexibility to allow the physician to select the code that is specific to the greatest extent known about the patient’s problem. Finally, coders will be challenged to obtain sufficient information to assign the appropriate ICD-9 code(s).

Physicians can ease the transition by documenting specific diagnostic statements in their progress notes and utilize the most specific diagnosis code available. When using ICD-9 codes that are “unspecified” or “not otherwise specified” (NOS), the claim indicates that there is insufficient information in the medical record to assign a more specific code. If the physician selects a code that includes “not elsewhere classifiable” (NEC), the physician is stating that there is no ICD-9 code available that describes the condition.

**ICD-10 CODING**

The greatest change for many physicians is the need to specify site and laterality, e.g., right eye, left wrist, bilateral ears. In fact, laterality is one of the reasons for the increase in the number of codes available. For some diagnoses, ICD-10 also requires additional specificity by identifying the episode of care, e.g., initial, subsequent, sequela. We also find combination codes, e.g., acute cystitis with hematuria and much greater specificity, e.g., gestational diabetes mellitus in pregnancy, diet-controlled.

## Are you subconsciously ignoring the future?

Many in the physician community believe it will be easy to transition their current unspecified *ICD-9* codes to unspecified *ICD-10* codes. In our opinion, this is a grave misunderstanding. As reimbursement moves away from payment for quantity to payment for quality, we believe that in addition to meeting quality standards, physicians will need to use specific *ICD-10* codes that paint the picture to show what is going on with the patient. This specificity will assist the payer in determining medical necessity for visits, diagnostic tests, and procedures.

According to the American Academy of Professional Coders, some payers have already decided they will reject claims that include an unspecified code as the primary diagnosis for a service included on the claim. If this happens, it very well may be that the rejection will not be a denial and may not have an appeals process. In this scenario, the practice will need to determine the specific *ICD-10* code and submit a new claim. In addition to recoding, we believe the physician will also have to make an addendum to the patient's medical record for that date of service to indicate the appropriate diagnostic statement for the patient's problem to support the diagnosis code reported on the claim.

Think all of this is far-fetched and being written by a crazy woman? We are already seeing Medicare Local Coverage Decisions (LCD) with different frequency standards for diagnostic tests based on the patient's diagnosis. The frequency for one diagnosis may allow payment for the test on an annual basis, yet payment for another diagnostic test may allow payment for the test performed once a month. Most payers include a list of "approved" diagnosis codes in their medical policies. Payers like the idea of data-mining. They can track detailed utilization data through the claims processing system.

### **Time is Flying By! October 1, 2013 is only 25 Months Away Think First – 5010**

Before we even think about *ICD-10*, you need to consider the practice's ability to submit claims using the 5010 electrotonic claim standard. As of January 1, 2012, all claims submitted in 4010 format will be rejected. Practices having 10 or more employees must file electronic claims; you cannot drop claims to paper while you scramble to catch up to the 5010 standard.

The first question is whether the vendor for your practice management system and clearinghouse has tested with your Local Medicare Contractor and been approved for production in the 5010 Errata version. If they have successfully tested, they can move to production whenever they are ready.

Another question is whether the vendor has explained changes in the data required for the 5010 format. For example, physicians are required use the appropriate 9-digit ZIP code (ZIP + 4) in the electronic equivalents of Items 32 and 33:

Item 32	Enter the name and address, and ZIP +4 code of the facility patient's home, or physician's office based on the place of service used in Item 24b. this is a Required field
Item 33	Enter the provider of service/supplier's billing name, address, ZIP + 4 code, and telephone number. This is a required field.

Don't forget, if you also bill the DME Medicare Administrative Contractor for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), the patient's home address needs to be included in the electronic equivalent of Item 32. In this scenario, when filing claims for covered DMEPOS items, you will need the patients' ZIP+4 for DMEPOS claims.

The practice should have a process for obtaining the ZIP+4 for all addresses. Once in the 5010 format, ZIP+4 should be added to the facility database. Since most of us haven't gotten in the habit of using ZIP+4, for me the easiest way to obtain the information is through the United States Postal Service (USPS) website at <http://zip4.usps.com/zip4/welcome.jsp>

The compliance date for implementation of the *ICD-10-CM* is **October 1, 2013** for all covered entities as defined by the Health Insurance Portability and Accountability Act (HIPAA). *ICD-10* is NOT an update to *ICD-9*, it is an entirely

new coding system! *ICD-9-CM* includes approximately 16,000 codes; *ICD-10-CM* includes approximately 70,000 codes. *ICD-10* codes are longer and use more alpha characters

Don't forget, this isn't just a Medicare change, the entire health care system will transition to *ICD-10* on 10/1/2013. This transition affects physicians, hospitals, insurers, all government payers (including Medicaid), hospices, pharmacies, home health agencies, clearinghouses, etc. Many economists have estimated that the health care system will spend more money transitioning to *ICD-10* than we spent getting ready for Y2K!

### **Have you started your preparations?**

Have you performed an assessment of the practice? (Not all-inclusive)

- *ICD-9* Codes  
Who in the practice uses *ICD-9* codes?  
How do they use the codes?  
Who will need training?  
What is the extent of training they will need?  
Preferred method of training?  
Budget for training?
- How specific are the diagnostic statements in patient medical records?  
Is physician training needed? If yes, who will train?  
Can technicians help physicians provide complete diagnostic statements?
- What is the status of your current practice management system?  
Physicians need to prepare to run two (2) diagnosis coding systems beginning 10/1/2013. Determination of when to use *ICD-9* and *ICD-10* is based on the **date of service**, not when the claim is filed.

Many scenarios will exist after October 1, 2013 when physicians will need to use *ICD-9*. For example, a hospital inpatient is admitted 9/27/2013 and discharged 10/3/2013. At this time, in this scenario, it appears we will file two claims. The first claim will include dates of service 9/27/2013 through 9/30/2013; the second claim will include dates of service 10/1/2013 through 10/3/2013.

Another example will be a patient covered by an insurance plan that is primary to Medicare. The primary insurer's payment for dates of service on or before 9/30/2013 may not be received until on or after 10/1/2013. The MSP claim must be filed with *ICD-9* codes even though the claim is being submitted after the transition to *ICD-10*.

Although we try to get every claim submitted to the correct payer, there are always situations when the claim is submitted to one insurer only to find out that the claim should have been submitted to another payer. If the date of service is on or before 9/10/2013, you will still use *ICD-9* diagnosis codes.

The question you should be asking your vendor is whether your current practice management system is capable of running two complete sets of diagnosis codes. Is it time to upgrade, add more memory, etc.

- Will the practice be using paper charts or an electronic health record (EHR)?
- Will the practice try to use paper superbills or electronic charge capture?

As we move forward, I think we can count on one of two things happening:

- The Mayans had it right about 12/21/2012 and *ICD-10* won't be needed!
- Physicians and payers will be ready for *ICD-10* by October 1, 2013 or accounts receivables will go sky-high!