CODING
ICD-10: Understanding initial, subsequent and sequelae

Now that ICD-10-CM is finally here, you will need to familiarize yourself with new concepts such as initial, subsequent, and sequela classifications for diagnosis codes. Most coders and auditors are familiar with the concepts of initial and subsequent from using E/M codes to describe hospital visits. The initial visit typically describes the first visit by the admitting physician (or the consultant when the payer doesn’t recognize consultation codes).

As providers follow the patients during a hospital stay, those services are billed with subsequent encounter codes. When the patient is discharged, then admitted again to the hospital at a later date, the process of starting with an initial code, then switching to subsequent codes is repeated.

The ICD-10 coding system brings the concept of initial and subsequent to diagnosis coding of injuries and poisoning, although it’s important to know that the terms are applied slightly differently. ICD-10-CM introduces a third concept, sequela, which applies to conditions that occur after subsequent treatment and after the acute phase of a disease or injury.

The ICD-10-CM Official Guidelines define the initial encounter diagnosis coding as the one to use “while the patient is receiving active treatment for the condition.” It goes on to say that this could be for surgical treatment, an emergency department encounter, or evaluation and treatment by a new physician.

- An initial encounter is denoted in ICD-10-CM by the seventh character of A.
- A subsequent encounter is defined as "encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase." Examples cited include a cast change, removal of a fixation device, or medication adjustment. In these encounters, the seventh digit of the ICD-10-CM code is D.

(continued on pg. 2)
Sequelae is used for the complications or conditions that arise as the direct result of a condition that is essentially considered to be otherwise resolved. For example, the guidelines cite the scar formation that occurs after a burn. In these cases, the first ICD-10-CM code used during the encounter is the reason for the visit.

In the example noted above, a patient being seen for the scar would have the scar listed as the first diagnosis code. The second code would be the sequela code for the underlying cause, which is the burn itself. In this case, the code would end with the letter S.

Let’s see how the ICD-10-CM coding would work with an actual burn example. The patient is being treated for burns to the left lower leg caused by scalding hot water that was being heated on the stove.

When the patient is treated in the emergency room, the doctor would code T24.032A for the burn of unspecified degree of the left lower leg, T31.0 because the burns occupied less than 10 percent of the body surface, and X12.XXXA for contact with other hot fluids.

Here is where it gets confusing. If the patient is treated in the emergency room for comfort care, then follows up with another physician as an outpatient for active treatment, that second physician will continue to use the A for active encounter. The code selections would be the same.

If the patient receives treatment in the hospital, then follows up with the same physician as an outpatient, the physician would then use T24.032D for the burn and X12.XXXD for the contact with other hot fluids.

If the patient needed to have a surgical intervention to treat the burns, the A would continue to be used as the seventh character for the surgery because the burn would be considered to be under active treatment.

These codes would continue to be used for all visits during the routine follow-up treatment phase of the burn, regardless of the number of encounters.

Now, let’s say the burns have healed and the patient now has a scar on the left leg and is being treated for the scar. In this case, the primary diagnosis would be 190.5, for the scar condition of the skin. The burn code would now be considered a sequela, so the second code would be T24.0032S to explain the reason for the scar.

It may take time, but you’ll soon be comfortable enough with initial, subsequent, and sequelae to apply them routinely.

— Scott Kraft, CPC, CPMA (skraft@drsmgmt.com). The author is an Auditor and Consultant at DoctorsManagement.

## Early days: ICD-10 claims are a mixed bag so far

It’s still too early to draw any conclusions about the revenue cycle impact of ICD-10 implementation, but signs are mixed so far. Most practices are reporting that ICD-10 claims have been accepted without incident, while others are seeing claims rejected for a variety of reasons.

As this issue of The Business of Medicine went to press, only a handful of practices submitted ICD-10 claims quickly enough to have seen them paid. One orthopedic practice in Louisiana saw two claims with ICD-10 get paid, and the staff is already celebrating this minor success. More broadly, most of the impact so far has fallen on the providers and coders. Online, some of the most heavily broadcast “tweets” on the #ICD10 hashtag have come from providers and coders who have had to adjust their daily workflow to select correct diagnosis codes from the much larger list of available ICD-10 codes.

The November issue of The Business of Medicine will have more data, reaction, and in-depth analysis of the impact of ICD-10 after providers get a few billing cycles under their belts.

## Medicare Rules

### CMS releases final stage 3 meaningful use rule

You can breathe a little easier if you have an electronic health record (EHR) system or are planning to transition to one in the next two years. CMS has released the final rule for Stage 3 of its EHR meaningful use (MU) program, which gave providers financial incentives for adopting EHR and meeting specific
reporting requirements or penalties for not doing so. Stage 3 is the final phase of the MU program and, thanks to this final rule, will now be optional on Jan. 1, 2017 – effectively pushing back the implementation date to Jan. 1, 2018.

This final rule also incorporates some long-awaited updates to Stage 2 MU rules, which had previously been contained in a separate “modifications” rule. Here’s a breakdown of key provisions in the consolidated Stage 3 final rule.

**Stage 2 modifications rule**
The Stage 2 modifications rule, long-awaited, removes reporting measures that are “redundant, duplicative” or no longer relevant, according to CMS. It also changes some of the patient engagement requirements to be more in line with the Stage 3 rule. Most importantly, the Stage 2 modifications rule allows providers to attest to a meaningful use reporting period of any 90 contiguous days in CY 2015. For CY 2016, first-time participants can use any 90-day contiguous period in 2016. Both of these measures have made it in the Stage 3 MU final rule.

**Stage 3 final rule**
Meaningful use Stage 3 is set to begin on Jan. 1, 2017, but the 2017 reporting year will be optional in terms of Stage 3 requirements. On Jan. 1, 2018, the stage 3 requirements become mandatory.

- To simplify and consolidate the reporting measures, CMS will require eight (8) overall objectives in Stage 3, with one or more measures per each objective, eliminating the core/menu measure system in Stage 1 and 2.
- In Stage 3, more than 60% of the proposed measures require interoperability, up from 33% percent in Stage 2.
- Vendors will benefit from the use of application program interfaces (APIs) that enable better EHR-to-EHR communication and better data access for patients.

The individual objectives and measures for Stage 3 include increased thresholds over Stage 2, although the final rule implements flexible reporting periods that are aligned with other CMS incentive programs in an attempt to reduce reporting burdens for providers. The flexible reporting periods will shift from fiscal year to calendar year reporting for all providers effective back in 2015 and going forward. A 90-day reporting period will be accepted in 2015 for all providers, for new participants to the MU program in 2016 and 2017, and for those providers who voluntarily attest to Stage 3 in 2017, the optional year. **Note:** Full-year reporting periods will be required for 2018 and beyond.

Industry reaction has been varied. More than 60% of hospitals and nearly 90% of physicians have yet to successfully attest to Stage 2 requirements, said Rick Pollack, president and CEO of the American Hospital Association, in a prepared statement. “[The Stage 3 rules] are a mixed bag for hospitals and health systems and the patients they serve,” Pollack said. The Stage 3 deadline in 2018 is still far too soon given how few providers have been able to meet Stage 2, he said.

With so few physicians attesting to Stage 2 rules, which boast increased thresholds for reporting metrics, “significant changes” to the Stage 3 rules will be needed to secure participation from physicians, said Steve Stack, MD, president of the American Medical Association. Vendors are another major stakeholder and their readiness for Stage 3 can’t be taken for granted, he said. “We also want to make sure that EHR vendors have the time they need to further test products for interoperability, usability, safety, and security.”
Is it really final?

In a move that somewhat muddies the waters, CMS is allowing a 60-day comment period for the final rule, which gives stakeholders additional time to sound off on the provisions. This is rarely seen in the rulemaking process for HHS, which has led some industry experts to speculate that CMS and HHS aren’t as confident in the feasibility of the Stage 3 requirements as they were for Stage 1 and Stage 2.

— Grant Huang, CPC, CPMA (ghuang@drsmgmt.com). The author is Director of Content at DoctorsManagement.

ACCOUNTING

How to take advantage of Georgia’s retraining tax credit

As an owner of your practice, you know how valuable new productivity technologies and formal training can be, but there’s often an expensive ramp-up cost associated with implementing new tools or training your employees. You lose a half-day of work so your team can host a practice wide meeting to train everyone on how to use the new EMR software.

You already know that investing in new technologies and training your employees is not only necessary, it’s vital to growing your practice. But did you also know that the state of Georgia wants to give you a competitive advantage by helping businesses pay for that training?

The Retraining Tax Credit helps Georgia businesses pay to train existing employees on new technologies, including new software, software upgrades or additional modules, customized systems, and even business process changes.

Your company may be able to receive a tax credit up to 50 percent of its direct training expenses for these programs, whether someone in your organization is providing the training or you bring in outside help. Businesses are eligible for a $500 tax credit per full-time employee, per training program, with an annual cap of $1,250 per employee. For example, a physician practice with 50 employees conducting qualified training programs could receive a Georgia tax credit of up to $62,500!

These retraining tax credits can be used to offset up to 50% of a company’s Georgia corporate income tax liability. The law even includes carryforward provisions for companies that spend more than the maximum credit allowed in any one year. Unused credits can be carried forward for up to ten years and applied to future years’ tax liability.

Your company may be able to double its tax credits for rolling out a new EMR or other substantial productivity upgrade. That means a 50-employee company might be able to generate $125,000 in tax credits!

Here’s how it may work. Begin a software rollout and conduct the initial training in 2014 (first tax year), then complete the training in 2015 (second tax year). Here is a sample training scenario below as an example:

- Conduct initial training in 2014
- Provide overview & introduction training to all employees, with coffee & donuts;
- Review major business processes that will be affected by any new systems, such as a practice management system, an EHR, a lab system, or an accounting system; and
- Explain how new software will affect departmental platforms/changes.
- Complete training in 2015

Visit www.doctors-management.com for details today.
• Provide individualized training for each employee’s specific job or task areas, such as billing, new patient review, and e-prescribing; and

• Provide job-specific training on how to use the new software for those who work, for example, in billing, insurance, accounts payable and journal entry.

If you time your roll-out of a major technology shift and structure training to occur over two tax years instead of conducting all training in a single tax year, your business can have better trained employees, boost productivity, and qualify for twice the tax credits ($2,500 per employee instead of $1,250).

— Patrick Wilbanks (pwilbanks@alpharesults.com). The author is a Tax Credit Specialist at Alpharesults LLC, a tax management and administration firm specializing in state income tax credits and incentives.

COMPLIANCE

New DoJ memorandum is a compliance game-changer

A recent memorandum released by the U.S. Department of Justice (DoJ) could have major implications for healthcare compliance, specifically in scenarios where an internal investigation needs to be conducted in a healthcare provider organization.

At DoctorsManagement, we provide compliance assistance in the form of coder and provider education, risk management, and claims audits, and we believe the DoJ memo is a game-changer for us. The new guidance, known as the “Yates Memorandum,” significantly increases individual accountability for corporate wrongdoing and will likely force compliance professionals, corporate officers and directors to reevaluate the reliability of their current compliance program, as well as review their overall operations from a compliance standpoint. As it relates to these changes, “cooperation” is “all or nothing,” meaning that companies won’t get credit for cooperating without identifying culpable individuals and divulging all relevant facts.

What this means is simple: Without full disclosure, companies won’t get credit for cooperation. Companies must divulge all relevant facts about an individual’s (or multiple individuals’) misconduct irrespective of their position within the company.

The Yates Memorandum has been billed as a new initiative intended to take on corporate misconduct and hold individuals accountable for corporate wrongdoing. The memorandum includes six specific criteria designed to guide prospective enforcement against “C-suite” individuals.

The changes listed below will be incorporated into the U.S. Attorneys’ Manual and are expected to supersede the factors for prosecuting business organizations from the prior guidance, the 2008 Principles of Federal Prosecution of Business Organizations.

Yates Memorandum: Six key provisions

1. To be eligible for any cooperation credit, corporations must provide to the DOJ “all relevant facts” about the individuals involved in the corporate misconduct.

2. Both criminal and civil corporate investigations should focus on individuals from the inception of the investigation.

3. Criminal and civil attorneys handling corporate investigations should be in routine communication with one another.

4. Absent extraordinary circumstances, no corporate resolution will provide protection from criminal or civil liability for any individuals.

5. Corporate cases should not be resolved without a clear plan to resolve related individual cases before the statute of limitations expires, and declinations as to individuals in such cases must be memorialized.

6. Civil DOJ attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit against an individual based on considerations beyond that individual’s ability to pay.

These provisions will pit companies against individuals because it essentially eliminates the concept of partial credit. Companies must weigh their risk very carefully to determine if full and complete voluntary disclosure is worth the cooperation credit. We foresee many corporate officers forcing suspected wrongdoers out so it’s easier to make a case that the company was proactive in working to mitigate risk, and took action upon gaining knowledge of any misbehavior on the part of those individuals.
The Yates memorandum sets out to target individuals and force companies to expose individuals and make those individuals completely liable in order to receive cooperation credit during an investigation. It is important to understand that the memorandum does not constitute binding law; its stipulations apply to all pending matters and future investigations of corporate wrongdoing by the federal government. At this time, it’s unclear exactly what effect the guidance will have on individual prosecutions and corporate resolutions.

We recommend that practices speak with legal counsel regarding voluntary disclosure and the pros and cons of disclosure to receive cooperation credit.

— Sean M. Weiss, CPC, CPC-P, CPMA, CCP-P, CMCO, ACS-EM (sweiss@drsmgmt.com). The author is a Partner, Vice President and Chief Compliance Officer at DoctorsManagement.

### PRACTICE MANAGEMENT

#### What you need to know about credit card ‘chip’ technology

If you’ve received a new credit card in the mail recently, there’s a good chance it has a shiny gold-colored chip embedded in its plastic surface. These are actually microprocessor chips that store and protect cardholder data, and they are fast becoming the global standard for credit card and debit card payments.

Called “EMV” after its original developers (Europay, MasterCard, and Visa), this technology is supposedly more secure than the traditional magnetic stripe. When Canada implemented EMV technology in 2011, credit and debit card fraud dropped an amazing 73% and the U.S. is now hoping for similar results. Physician practices need to be aware of this new technology. Let’s take a look at how practices will be impacted.

#### Liability and risk to practices

Today, if a card-present transaction is conducted using a counterfeit, stolen or otherwise compromised card, the financial loss from that transaction falls back on the bank that issued the card. After the Oct. 1, 2015 deadline created by major U.S. credit card issuers MasterCard, Visa, Discover and American Express, the liability for card-present fraud will “shift” to whichever party is the least EMV-compliant in a fraudulent transaction.

This means that your practice could be held liable for these types of fraudulent transactions causing chargebacks to your business resulting in related fees, administrative time and ultimately not getting paid for rendered services. The likelihood of fraud in a medical practice may not seem like a threat or high risk, especially when a practice takes many co-pays under $50.00. This is something you should seriously consider and have an actionable plan in place.

### Will our practice be able to accept these new cards?

During the initial period of the U.S. migration to EMV, the new chip cards will still include the magstripe as a fallback, so you won’t need to worry about being unable to accept a credit card payment at the time of service.

#### Tips for EMV migration in your practice

Here are some suggested steps for ensuring that EMV won’t negatively impact your practice and revenue:

- **Training and product awareness** at both the business practice and the employee level is crucial to a successful implementation. As EMV acceptance is very different than the traditional magstripe (the card is inserted headfirst into a terminal as opposed to being swiped horizontally, for example), it’s important for your front desk staff to become familiar with the new requirements so the patient experience can be as smooth as possible.

### DoctorsManagement acquires MI Professional Management

After a period of discussions with MI Professional Management of Kingsport (PM), DoctorsManagement is happy to announce that as of Oct. 1, 2015, PM will be part of our company. The consultants at PM have earned well-deserved reputations in the healthcare industry as ethical, knowledgeable and outstanding advisors. We are pleased that they have chosen to join DoctorsManagement and apply their skills and experience to our client work. DoctorsManagement will absorb PM’s clients, which represent multiple specialties, mostly from the Tri-State area.
• **Get a business plan together** to first make the change and before actual implementation begins. As EMV equipment upgrades have the potential to be both costly and time consuming, it’s best to get started by contacting your DM consultant or your current payment processing provider. You should not only consider the cost of upgrading your POS terminal, which can vary from $200 to $1,000 or higher, but also the patient perception and maintaining PCI and HIPAA compliance. The change in the way we will pay and accept payments in the U.S. is inevitable, and when investing in new card reader terminal, you will want to make sure you are future-proofed for EMV and Chip card readers.

• **Don’t wait to migrate.** You may begin to feel the pressure once the EMV card migration starts to reach its critical mass – with issuing banks beginning to issue chip cards to new and existing customers. Businesses that have not already migrated to EMV may consequently have to answer to their customers as to why they have to continue to swipe their new chip cards – especially when the market presents chip technology as the safer way to pay. Don’t wait until the last minute to migrate your business.

If any of this resonates with you, do some research and find a provider that’s a fit for your specific needs.

— Doug Dominique, BSBA-MKG (doug.d@heritageps.net). Doug is Area Sales Director for Heritage Payment Solutions, an electronic payment processing company in Wake Forest, NC.

### REVENUE CYCLE MANAGEMENT

**Know your rights when payers try to recoup payments**

Before your practice pays back any money following a recoupment demand from an insurance plan, make sure your rights are protected, and don’t fall victim to payer scare tactics.

That’s the message from Thomas Force, expert healthcare attorney and president and founder of The Force Group, a healthcare revenue recovery and advocacy company based in Lindenhurst, N.Y.

Force, who has served as chief compliance officer for a health insurer, will share his strategies for how to defend yourself against commercial insurer audits at the upcoming NAMAS Conference from Dec. 6 through Dec. 9 in Nashville, Tenn.

However the insurance plan approaches you to try to get you to pay back money, Force says to remember that the Employee

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**DoctorsManagement featured at MGMA Annual Conference**

Three DoctorsManagement experts were featured speakers at the Medical Group Management Association’s (MGMA) 2015 Annual Conference in Nashville, Tenn., from Oct. 11 to Oct. 14. Frank Cohen, Director of Analytics, taught sessions on measuring physician productivity and statistics for practice managers, using his unique, data-driven compliance approach. Valora Gurganious, Senior Management Consultant, presented a session on conducting a practice assessment, enabling attendees to accurately review all the business aspects of a medical practice. Jennie Hitchcock, Practice Management and Compliance Consultant, presented a session on practice management from a leadership and professional development standpoint. All three were able to share some of the expertise and knowledge our clients rely on with practice executives from across the nation.
Retirement Income Security Act of 1974 (ERISA) affords you certain rights during the recoupment process, including:

- Written notice with the specific reason for the audit and recoupment;
- Written notice that you have the right to review all relevant claim documents and materials without charge; and
- Written notice of the specific plan provisions on which the repayment determination is based, including references to specific plan documents and citations of exclusions.

That’s not all, according to Force. As the recoupment process is an adverse benefit determination against the provider, you’ve got the right to review material relevant to the recoupment determination, including internal emails and documents the plan used to make the determination.

Private payers are seeing the amount of money Medicare and Medicaid plans are recouping from providers, and they’re becoming more aggressive than ever in going after repayment demands.

In addition, new technology is ensuring that all private payers are getting much more detailed information about all provider claims, including repayment demands made by other providers. That’s why it’s more important than ever that you know your rights, and you’re able to protect your practice’s bottom line from aggressive recoupment demands from commercial payers.

Tom Force will talk about your rights, as well as the tactics that have made him so successful advocating for physician practices at the NAMAS Conference in Nashville starting on Dec. 6. Don’t miss this opportunity! See the entire agenda and register today at http://namas.co/events/namas-conference.

— Scott Kraft, CPC, CPMA (skraft@drsmgmt.com). The author is an Auditor and Consultant at DoctorsManagement.

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### New DoctorsManagement clients

<table>
<thead>
<tr>
<th>Client</th>
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<tbody>
<tr>
<td>Pediatric group, NY</td>
<td>Practice valuation</td>
</tr>
<tr>
<td>Plastic surgery practice, GA</td>
<td>Practice start-up</td>
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<td>Compliance firm, LA</td>
<td>Coding seminar</td>
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<td>Dermatology group</td>
<td>Post-audit extrapolation mitigation</td>
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<td>Research/develop out-of-network fee schedule</td>
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<td>Practice assessment and compensation review</td>
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<td>Ophthalmology group</td>
<td>Practice assessment</td>
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<td>Billing services</td>
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<td>Provider registration</td>
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<td>Nurse practitioners, KY</td>
<td>Credentialing services</td>
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<td>CMPM training</td>
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<td>HR consulting services</td>
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<td>Managed care negotiations/monthly services</td>
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<td>CLIA inspection preparation</td>
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<td>Power buying/GPO enrollment</td>
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