

Leading the way

A Newsletter for Providers of Medical Associates Health Plans



Medical Record Documentation

Complete medical records are the cornerstones of quality healthcare. Well-organized, legible medical records allow for a clear picture of the patient's complaint, symptoms, procedures, medical treatments, status, and the outcome of care.

In compliance with both the National Committee for Quality Assurance and Medicare, we offer the following recommendations:

Patient medical information is kept confidential and well organized.

Each page in the chart has patient name and ID number.

Medical history includes current and past diagnoses, surgeries, allergies, adverse reactions, and immunizations. Family history of parents, grandparents, and siblings.

Documentation of each patient visit including subjective, objective, lab, x-ray, action, treatment, medications, therapies, all consistent with diagnosis.

Evidence of continuity and coordination of care between primary and specialty physicians; evidence of preventive health screenings/ services offered.

Planning for ICD-10 implementation



The compliance date for ICD-10 implementation is October 1, 2013. Due to the expected complexity of the changes, it is not too soon to start planning your ICD-10 implementation.

Currently, ICD-9 has three volumes. Volumes one and two consist of inpatient and

outpatient diagnosis coding, and volume three is for inpatient procedure coding.

ICD-10 consists of two codes sets: ICD-10-CM for inpatient/outpatient diagnosis coding, and ICD-10-PCS for inpatient procedure coding.

Implementing ICD-10 will mean four primary things:

- Changing the terminology of medicine – the words we use to describe medical conditions.
- Changing the coding of these new terms into numbers that can be used in systems.
- Changing business processes to gain opportunities available by new level of coding.
- Changing all “systems” – provider, payer, financial, legal, regulatory, and academic (who use coded diagnostic information).

There are significant changes in terminology that will require significant new thinking for both documentation and interpretation to assure accurate coding of both diagnosis and institutional procedures.

ICD-10 is considered a much bigger and more complex project than Y2K – start planning today!

The chart to the left details the differences between ICD-9 and ICD-10 diagnosis codes. Turn to the reverse side to view the differences between ICD-9 and ICD-10 procedure codes.

ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
3-5 characters in length	3-7 characters in length
13,000 codes	68,000 codes
First digit is alpha (E or V) or numeric, and digits 2-5 are numeric	First digit is alpha, digit 2 is numeric, and digits 3-7 are alpha or numeric (alpha digits are not case sensitive)
Lacks detail	Very specific
Codes are non-specific	Specificity improves accuracy and richness of data for analysis
Does not support interoperability	Supports interoperability and exchange of health data between other countries and the U.S.
Gestational Diabetes=648.83	Gestational Diabetes=024.429

Procedure codes on reverse

Credentialing Update

Recently, our Credentialing Committee and Board of Directors have reviewed the policies regarding Board Certification for new and existing practitioners.

The following paragraphs describe the changes made, effective for all new physician participating with Medical Associates Health Plans after October 1, 2010:

Any new MD, DO, DPM, Physician Assistant, Nurse Midwives, and Nurse Practitioners will be required to be Board Certified or Eligible in their primary specialty of practice.

If Board Certification is not obtained in the primary specialty of practice within the Board Eligibility timeframe, the practitioner may lose participation in MAHP network. The Credentialing Committee will evaluate the Board Certification status at the time of recredentialing.

The provider is to apply for certification within five years of postgraduate training and be certified within seven years after application.

For current participating physicians:

All surgeons who were approved as participating providers prior to September, 1993 (general, oral, orthopedic, plastic, thoracic, etc.), must be ABMS or AOA specialty Board Certified or have completed the Board Eligibility prerequisites.

Surgeons who do not meet this requirement will be allowed to retain their providership but could lose providership for other reasons.

All physicians credentialed after January 1, 2005, must be ABMS or AOA Specialty Board Certified or Eligible.

Any MD, DO or DPM who is not Board Certified prior

Planning for ICD-10 (continued from pg 1)

ICD-9-CM Procedure Codes	ICD-10-PCS Procedure Codes
3-4 numbers in length	7 alpha-numeric characters long
All digits numeric	Each digit is either alpha or numeric (alpha digits are not case sensitive, and letters O and I are not used to avoid confusion with numbers 0 and 1)
3,000 codes	87,000 codes
Lacks detail	Very specific
Generic terms for body parts	Detailed descriptions for body parts
Limits DRG assignment	Allows DRG definitions to better recognize new technologies and devices
Angioplasty=39.50	1170 codes to replace this one code; an example is 047K0ZZ Angioplasty: Dilatation of Right Femoral Artery-Open Approach

This chart shows differences between ICD-9 and ICD-10 procedure codes.

to October 1, 2010, will not be required to become Board Certified and/or certified in their primary specialty.

After October 1, 2010, the Credentialing Committee

will determine the continued participation in MAHP of practitioners who have allowed their Board Certification in their primary area of practice to lapse.

For Your Information . . .

Communication

All practitioners participating with Medical Associates Health Plans may freely communicate with patients regarding treatment options available.

This may include medical care, risks, benefits, consequences of treatment or non-treatment, the opportunity to refuse treatment, and to express preferences about future treatment.

Confidentiality

MAHP maintains a quality improvement program covering all aspects of our activities, which is reviewed and updated every year.

We make copies of our Quality Improvement (QI) Plan, Quarterly QI Reports, and Preventive Guidelines available to providers and members. To obtain a copy, please contact QI at 563-556-8070 or 1-800-747-8900. Our Preventive Guidelines are also online at mahealthcare.com/prac_guide.htm.

Utilization

Utilization Management (UM) decision making is based only upon appropriateness of care and service, and existence of coverage.

Medical Associates does not reward practitioners or others conducting utilization review for issuing denials of coverage or service care.

Financial incentives for UM decision makers do not encourage decisions resulting in underutilization.

Medicare

We provide covered services to Medicare beneficiaries in a professional manner and do not discriminate in the provision of services.

As providers' practice capacity permits, we accept enrollees as patients without discrimination due to payment source, race, color, religion, national origin, sex, age, mental or physical disability/handicap, sexual orientation, genetic information, or with due regard to an illness.