



Preparing for the 5010 - ICD-10-CM Transition

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Disclaimer

This presentation was current at the time it was written. Every reasonable effort has been made to ensure the accuracy of this information through current editions of CPT and ICD-10 CM, and local Medicare policy. Proper coding may require analysis of statutes, regulations or carrier policies, and as a result, the proper code result may vary from one payer to another. Our responsibility is to render current coding information and advise accordingly. It is always the provider's responsibility to determine and submit appropriate codes, modifiers and charges for the services that were rendered. This presentation is intended for personal use only. Re-sale of the content is prohibited. All rights reserved.

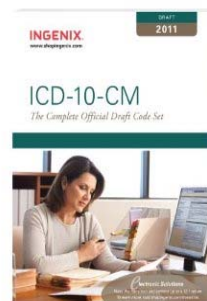
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Agenda

- What – is changing
- Why - change
- When – the timeline
- Who – is affected
- How – to use the coding system
- Implementation Issues
- What – to do to prepare
- Learn More About It



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What is Changing ?

4010 Current Claims Transmissions	5010 Claims Submissions as of January 1, 2012
ICD-9-CM Diagnosis Codes Volume 1 & 2 Utilized by all types of healthcare providers	ICD-10-CM Utilized by all types of healthcare providers
ICD-9-CM Procedure Codes Volume 3 Utilized by inpatient hospitals	PCS – Procedure Coding System Utilized by inpatient hospitals
CPT – Current Procedure Terminology Utilized by all ambulatory and healthcare provider reporting	No Changes

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Version 5010

- 4010 – 5010
 - The format by which your electronic claims are sent
 - Currently they are sent with the 4010 electronic version
 - The switch is being made to 5010
 - Final rule January 16, 2009
 - No effect paper claims
 - They are 5010 compliant

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Version 5010

- 4010 – 5010
 - Effects all providers, health plans and clearinghouses who electronically submit administrative transactions
 - Claims
 - Verification of patient's eligibility
 - Receive remittance advice
 - Effective January 1, 2012

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Version 5010

- Why the change?
 - To accommodate the new format of the ICD-10 codes (7 alpha-numeric characters)
 - Provide an indicator for patient on admission (POA) for institutional claims
 - Require anesthesia time to be reported in minutes and not units for all carriers



Version 5010

- Why the change?
 - Clarify subscriber and dependent relationships
 - Fully supports the National Provider Identifiers (NPI)
 - Auto - adjudication



Version 5010

▪ Challenges, Concerns & Issues

- Billing Provider Address
 - May NOT be a P.O. Box
 - It must be a physical address associated with the NPI subpart
 - The pay to address (Loop 2010AB) can still contain a P.O. Box address (Pay to Address)
 - In some cases the payer uses the address of the provider listed in their provider files and not the address submitted on the claim form(OK) and in some cases uses the information from the claim form (May not be OK)
 - If provider matching fails this the claim will be rejected



Version 5010

■ Challenges, Concerns & Issues

■ Software

- The billing address at the batch level is often reported as a P.O. Box
- The physical address may be reported at the claim/service level in the Service Facility Location
- Verify your software has the capability of sending the physical address for each batch of claims and the mapping moves the physical address into the billing address



Version 5010

■ Challenges, Concerns & Issues

- Determine how your billing system is reporting the billing address on claims
 - Work with your software vendor
- Determine the impact to enrollment with payers, if the address reported on the claim is used for matching in the provider files or NPI crosswalk, then the payer needs to be informed of the change.



Version 5010

■ Challenges, Concerns & Issues

– **Nine Digit Zip Codes**

- Required on billing provider and service locations



Version 5010


■ Challenges, Concerns & Issues

– **Drug Reporting**

- Injectable medications must include additional drug information
 - National Drug Code (NCD)
 - Quantity
 - Composite unit of measure and prescription number
 - Providers who submit drug charges must work with their software vendor to ensure that the CTP Segment is present if 2410 Loop (Drug Identification) is submitted.

5010 Timeline	
Date	Compliance Step
January 1, 2010	Payers and providers should begin internal testing of Version 5010 standards for electronic claims
December 31, 2010	Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance
January 1, 2011	<ul style="list-style-type: none"> • Payers and providers should begin external testing of Version 5010 for electronic claims • CMS begins accepting Version 5010 claims • Version 4010 claims continue to be accepted
December 31, 2011	External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance
January 1, 2012	<ul style="list-style-type: none"> • All electronic claims must use Version 5010 • Version 4010 claims are no longer accepted
October 1, 2013	<ul style="list-style-type: none"> • Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures • CPT codes will continue to be used for outpatient service

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Version 5010

- What to do to prepare?
 - Software vendors
 - Is your software 5010 ready?
 - When can you begin testing?
 - Will you need a software upgrade?
 - If so will your hardware support the change?
 - What costs are involved?
 - Ask for details
 - What is their project plan and time line?

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Version 5010

- What to do to prepare?
 - Clearinghouse
 - Some may provide 5010 assistance on a short term basis
 - Vendors
 - Various Insurance carriers
 - Testing
 - Begin testing as soon as possible
 - Ask your Practice Management Vendor for **277CA functionality or transaction acknowledgement**
 - Alerts you if your claims went through and if there are any problems.

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Version 5010

- What if they are not ready?
 - Express your concern
 - Follow-up, follow-up, follow-up
 - Prepare for a back up plan
 - Purchase a new system
 - Running two systems



The Back-Up Plan



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Back-Up Plan

- If your payers are not ready or uncertain if they will be ready ask for their contingency plan
 - What are the options?
 - Will claim processing be delayed?
 - Will your practice get interim payments?
- Remember as of Jan. 1 2012 sending/receiving claims in 4010 is in violation of the HITECH ACT

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Back-Up Plan

- Create an emergency budget for unexpected cash flow problems due to the transition
 - If the costs of keeping your practice running (e.g. light, heat power, salaries) is \$45,000.00 per month plan to keep at least 3 months reserve on hand
 - Delay any additional major purchases until after the transition



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Back-Up Plan

- Process all outstanding claims by December 31, 2011
 - Process claims daily
- Consider taking a business loan or line of credit
- If your practice is primarily Medicare based you will have fewer problems submitting claims
 - Mall Medicare Administrator Contractors MACs have tested and are 5010 ready

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ICD-10-CM

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ICD-10 Final Rule

- Published January 16, 2009
 - October 1, 2013 – Compliance date for implementation of ICD-10-CM and ICD-10-PCS (no delays)
 - No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes



Diagnosis Coding

- Uses for Diagnosis coding:
 - Calculate payment –Medicare Severity-Diagnosis Related Groups (MS-DRGs)
 - Adjudicate claims –diagnosis codes for all settings
 - Collection of statistical data
 - Assess quality

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WHY THE CHANGE ?

ICD-9-CM	ICD-10-CM
Outdated and obsolete classifications and terminology (30 years old) No longer utilized by other countries	Allow the USA to communicate better with other countries
No flexibility to add new diagnosis and procedure codes. Lack of expansion.	Provides flexibility to add new diagnoses and procedures
Not specific	Specifically identifies diagnoses and procedures
Difficult to collect and analyze data due to lack of specific codes	Enhance accurate payment for services rendered
Difficult to collect and analyze data due to lack of specific codes	Facilitate evaluation of medical processes and outcomes <ul style="list-style-type: none"> • Improved collection of data • Decrease the need for audits

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ICD-10-CM

- Who is Effected
 - Anyone who is covered by HIPAA:
 - Health care providers who conduct electronic transactions
 - Payers including Medicaid and Medicare
 - Clearinghouses
- Some non-HIPAA covered entities that use ICD-9 codes:
 - Vendors and business associates of covered entities
 - Worker's compensation programs
 - Life insurance companies

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ICD-10-CM

- ICD-10-CM implementation will impact every aspect of your medical practice
 - Medical necessity
 - Laboratory, Radiology, Physical Therapy Orders
 - Data entry
 - Authorizations & Pre-certifications



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ICD-10-CM

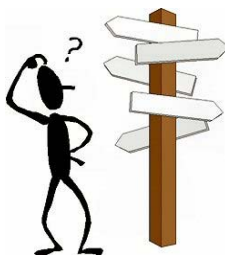
- Have a significant effect on billing and reimbursement
- All National and Local Coverage Determinations will change
- Collections – ICD-9-CM claims verses ICD-10 CM claims

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ICD-10-CM

- Patient confusion with explanation of benefits
- Increased denials
- Privacy Issues – due to specificity of the ICD-10 codes




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Overview of Changes



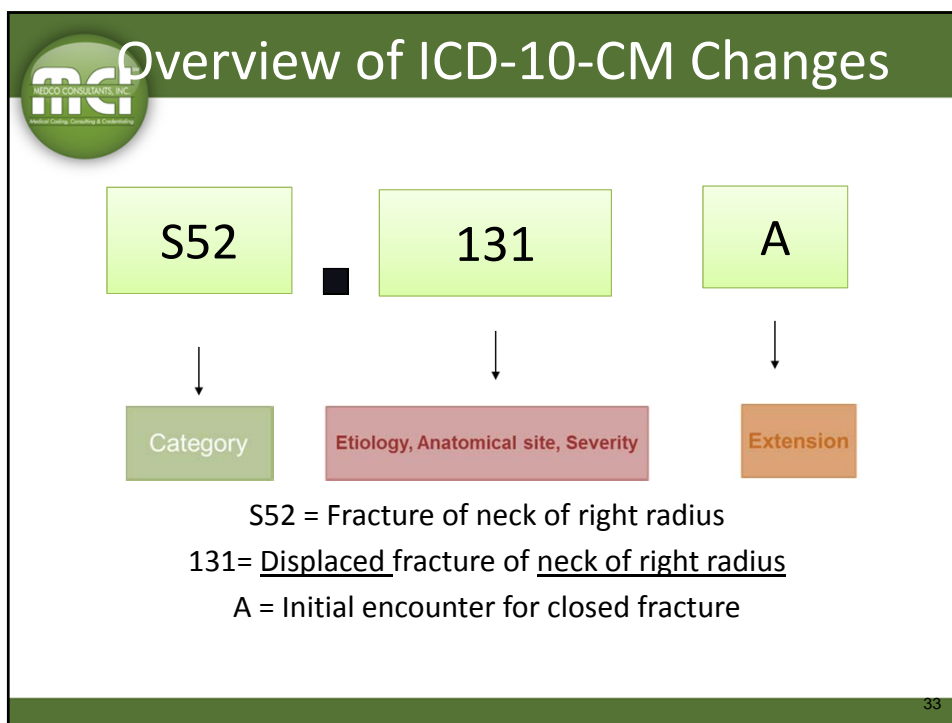
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Overview of ICD-10-CM Changes

- 3-7 digits
 - Digit 1 is alpha; Digit 2 is numeric
 - Digits 3-7 are alpha or numeric (alpha characters are not case sensitive)
 - Decimal is used after the third character
 - A48.1 Legionnaires' Disease
 - A69.21 Meningitis due to Lyme disease
 - S52.131A Displaced fracture of neck of right radius, initial encounter for closed fracture

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Overview of ICD-10-CM Changes

- Laterality
 - The right side is always character 1
 - The left side character 2.
 - In those cases where a bilateral code is provided the bilateral character is always 3
 - If no bilateral code is provided, assign separate codes for both the left and right side
 - The unspecified side is either a character 0 or 9 depending on whether it is a 5th or 6th character

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Overview of ICD-10-CM Changes

- ❖ C50.511 Malignant neoplasm of lower-outer quadrant of right female breast
- ❖ C50.512 Malignant neoplasm of lower-outer quadrant of left female breast
- ❖ C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast



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Overview of ICD-10-CM Changes

- Some ICD-10 codes require a 7th character
 - New concept
 - The 7th character must always be the 7th character
 - Some codes requiring a 7th character do not have 6 characters
 - In these cases a dummy placeholder “X” will be used to hold the place of the missing character(s)

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Overview of ICD-10-CM Changes

For example:

One of the following 7th characters is to be assigned to each code under category O35. 7th character 0 is for single gestations and multiple gestations where the fetus is unspecified. 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies. The appropriate code from category O30, Multiple gestation, must also be assigned when assigning a code from category O35 that has a 7th character of 1 through 9.

- 0 not applicable or unspecified
- 1 fetus 1
- 2 fetus 2
- 3 fetus 3
- 4 fetus 4
- 5 fetus 5
- 9 other fetus

O35.0 Maternal care for (suspected) central nervous system malformation in fetus

Maternal care for fetal anencephaly
Maternal care for fetal hydrocephalus
Maternal care for fetal spina bifida

EXCLUDES 2 chromosomal abnormality in fetus (O35.1)

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Overview of ICD-10-CM Changes

For example:

O35.0xx2 – Maternal care for (suspected) central nervous system malformation in fetus, fetus 2

- In this case a 7th character is required
- The dummy placeholder of “x” is used to hold the place of the 5th and 6th character
- This allows for the reporting of the 7th character

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Overview of ICD-10-CM Changes

Seventh Character Selection

A	Initial encounter for closed fracture
B	Initial encounter for open fracture type I or II
	Initial encounter for open fracture NOS
C	Initial encounter for open fracture type IIIA, IIIB, or IIIC
D	Subsequent encounter for closed fracture with routine healing
E	Subsequent encounter for open fracture type I or II with routine healing
F	Subsequent encounter for open fracture type IIIA, IIIB or IIIC with routine healing
G	Subsequent encounter for closed fracture with delayed healing
H	Subsequent encounter for open fracture type I or II with delayed healing
J	Subsequent encounter for open fracture type IIIA, IIIB or IIIC with delayed healing
K	Subsequent encounter for closed fracture with nonunion
M	Subsequent encounter for open fracture type I or II with nonunion
N	Subsequent encounter for open fracture type IIIA, IIIB or IIIC with nonunion
P	Subsequent encounter for closed fracture with malunion
Q	Subsequent encounter for open fracture type I or II with malunion
R	Subsequent encounter for open fracture type IIIA, IIIB or IIIC with malunion
S	sequela

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Overview of ICD-10-CM Changes

• Definitions of 7th Character extensions

- “A” – Initial encounter is used:
 - While the patient is receiving active treatment for the injury
 - Surgical treatment
 - Emergency department encounter
 - Evaluation and treatment by a new physician
- “D” – Subsequent encounter is used
 - After the patient has received active treatment of the injury and is receiving routine care
 - Cast change or removal
 - Removal of internal or external fixation device
 - Medication adjustment
 - Aftercare, follow-up visits

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Overview of ICD-10-CM Changes

- Excludes Notes:
 - In ICD-10-CM there are two excludes notes
- Excludes 1
 - pure exclusions
 - NOT CODED HERE
 - Two conditions that can not be reported together
- For example: a congenital form of a disease would never be reported with the acquired form of the same condition

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Overview of ICD-10-CM Changes

- Excludes 2
 - Not included here
 - The patient may have both conditions at the same time
 - In these cases it is acceptable to report both conditions if supported by the medical documentation

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Overview of ICD-10-CM Changes

Two types

- Excludes 1

Conditions listed with Excludes 1 are mutually exclusive. Not reported together.

Example:

G57.0 Lesion of sciatic nerve

Excludes1: sciatica NOS (M54.3-)

- Excludes 2

Conditions listed with Excludes 2 are not considered inclusive to a code, but may be coexistent, and if present, should be coded in addition.

Example:

G57.0 Lesion of sciatic nerve

Excludes 2: sciatica attributed to intervertebral disc disorder



Overview of ICD-10-CM Changes

Combination codes for certain **conditions & common associated symptoms and manifestations**:

K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding



Overview of ICD-10-CM Changes

Combination codes for **poisoning and their associated external cause**:

T42.3x2S Poisoning by barbiturates, intentional self harm, sequela

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Overview of ICD-10-CM Changes

- Obstetric codes **identify the trimester** instead of the episode of care:

O26.02 Excessive weight gain in pregnancy,
second trimester

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Overview of ICD-10-CM Changes

ICD-10-CM includes **clinical concepts**, (e.g. underdosing, blood type, blood alcohol level)

T45.516D – Underdosing of anticoagulants, subsequent encounter

Z67.31 – Type AB blood, Rh negative

Y90.1 – Blood alcohol level of 20-39mg/100 ml

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Overview of ICD-10-CM Changes

A number of **codes** have been **significantly expanded**: (e.g. injuries, diabetes, post-operative complications, etc.)

E10.359 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema

T82.01A Breakdown (mechanical) of heart valve prosthesis, initial encounter

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Overview of ICD-10-CM Changes

A distinction made between intraoperative complications and post-procedural disorders:

D78.02 – Intraoperative hemorrhage and hematoma of spleen complication other procedure

D78.22 Post-procedural hemorrhage and hematoma of spleen following other procedure

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ICD-10-CM

ICD-10-CM Includes

- An expansion of injury codes
- Many combination diagnosis/symptom codes
- Greater specificity in code assignment
 - 7 character alpha-numeric
- V and E codes are now main classifications
- Sense organs have their own chapter (moved from the nervous system)
- Injuries are grouped by anatomical site rather than injury category
- Postoperative complications are located within each procedure-specific body system chapter

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Overview of ICD-10-CM Changes

- Additional Changes:
 - New code definitions (e.g., definition of acute myocardial infarction is now 4 weeks as opposed to 8 weeks)



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Overview of ICD-10-CM Changes

- Sport injuries are coded with the type of activity and the reason for the injury



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Overview of ICD-10-CM Changes

- Activity Codes
 - Identify the activity at the time of injury
 - Are not primary codes
 - Located in category Y93
- Examples:
 - Y93.012 Skating (ice) (inline) (roller)
 - Y93.013 Horseback riding
 - Y93.014 Swimming
 - Y93.015 Golf Y93.016 Bowling
 - Y93.017 Bike riding

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Overview of ICD-10-CM Changes

- Reason Codes
 - W21.11 Struck by baseball bat
 - W21.12 Struck by tennis racquet
 - W21.13 Struck by golf club
 - W21.19 Struck by other bat, racquet or club
 - W21.210 Struck by **ice** hockey stick
 - W21.211 Struck by **field** hockey **stick**
 - W21.220 Struck by ice hockey puck
 - W21.221 Struck by field hockey **puck**

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Overview of ICD-10-CM Changes

- Place of occurrence
 - Y92.310 Basketball court
 - Y92.311 Squash court
 - Y92.312 Tennis court



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Implementation Issues



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Implementation Issues

- Myth DeBunking
 - Myth – The October 1, 2013 date is flexible and subject to change.
 - **FACT** – All HIPAA covered entities **MUST implement** the new code sets with dates of service, or date of discharge for inpatients, that occur **on or after October 1, 2013**
 - **FACT** – **HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS**

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Implementation Issues

- Training & Personnel
 - Crosswalks & Data Mapping
 - Information Technology (IT)
 - Business & Finance
- Considerations
 - Resistance to change
 - Identification of people who will require education and training

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Implementation Issues

- Training and Personnel
 - Senior management
 - HIM Managers
 - Utilization/Case Managers
 - Risk Management
 - Medical necessity coders (pre-certification, authorizations)
 - Contract managers
 - Clinical Coders
 - Physicians and clinicians

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Implementation Issues

- Training and Personnel (continued)
 - Compliance officers, Auditors
 - Data analysts
 - Software vendors
 - Quality Assurance management
 - Claims reviewers
 - Human resource managers
 - Data entry / Registration
 - Information systems personnel

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Implementation Issues

- Coders
 - Many of the ICD-10-CM conventions are similar to those of ICD-9-CM
 - These conventions will be understood by experienced coders
 - Challenges facing coders
 - Crosswalks
 - Lack of specific documentation
 - Understanding the new ICD-10-CM conventions (e.g. “x” place holders, Excludes 1 and 2, etc.)

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Implementation Issues

- Coders
 - Coders will need
 - Medical dictionaries
 - Brush up on medical terminology
 - Physiology
 - Specialty specific training
 - Anatomy charts
 - The level of detail in ICD-10-CM is much higher than ICD-9-CM

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Implementation Issues

- Coders

Example:

840.8 Sprains and strains of other specified sites of shoulder & upper arm

S46.111 Strain of muscle and tendon of long head of biceps, right arm

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Implementation Issues

Crosswalks and Data Mapping

- Gems (General Equivalent Mapping System) Files
- The purpose of the GEMs is
 - to create a useful, practical, code to code translation reference dictionary for both code sets,
 - to offer acceptable translation alternatives wherever possible.

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Implementation Issues

Crosswalks and Data Mapping

- Gems (General Equivalent Mapping System) Files
 - Can be used by all types of providers, payers and for other uses of coded data
 - Will be updated annually to keep current with changes
 - Will be maintained for a least three years after the Oct. 1, 2013 compliance deadline

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Implementation Issues

- Gems Files
 - Provide code translation two ways
 - From ICD-9-CM to ICD-10-CM
 - From ICD-10-CM to ICD-19-CM



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Implementation Issues

- Gems Files
 - Some codes will have a direct one to one match

Example:

Throat Pain 784.1
Pain in throat R07.0

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Implementation Issues

- One ICD-9-CM code can crosswalk into multiple ICD-10-CM codes

ICD-9-CM	ICD-10-CM
Abnormal Gait 781.2	R26.0 Ataxic gait R26.1 Paralytic gait R26.89 Other abnormalities of gait and mobility R26.9 Unspecified abnormalities of gait and mobility

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Implementation Issues

- Gems Files
 - Mappings from specific concepts to more general concepts are possible; however, it is not possible to use mappings to add specificity when the original information is general.

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Implementation Issues

Example: ICD-10-CM to ICD-9-CM GEM

S35.411A Laceration of right renal artery, initial encounter

To 902.41 Injury to renal artery

S35.412A Laceration of left renal artery, initial encounter

To 902.41 Injury to renal artery

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Implementation Issues

- GEMS Files

- There are some instances where there is no translation between an ICD-9-CM code and an ICD-10-CM

Example:

ICD-10-CM: Y71.3 Surgical instruments, materials and cardiovascular devices (including sutures) associated with adverse incidents

Has no translation in ICD-9-CM

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Implementation Issues

- Using the Gems Files

- Includes two mappings for the diagnosis codes
 - one in which ICD-9 is the source system and
 - one in which ICD-10 is the source system
- Each GEM has 5 Flags:
 - 1. The “approximate” Flag
 - 2. the “No Map” Flag
 - 3. A flag to indicate a one to many mapping
 - 4 & 5. Two flags to “further clarify one to many” mapping

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Implementation Issues

- Physicians Need to Understand:
 - The consequences of inadequate documentation
 - Denied claims
 - Delayed claims
 - The required level of detail in medical documentation
 - Specific terminology
 - Specificity
 - Laterality

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Implementation Issues

- Information technology
 - Bigger challenge than Y2K
 - Effect every electronic transaction (e.g. medical records abstract, utilization, billing, payment policies, claims submission, test ordering, clinical systems, etc.)



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Implementation Issues

- Additional concerns (to name a few)
 - Software interfaces
 - Report formats and layouts
 - Expansion of flat files
 - Coding edits and logic
 - In house custom applications
 - Forms – printed or electronic

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Implementation Process

The Implementation Process



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Implementation Process

- Implement an ICD-10 Task Force
 - Identify the team
 - Look for team players
 - Customized to fit the size and needs of your facility
 - Larger facilities may require an overall task force to drive the implementation process
 - Steering committee
 - Subcommittees, sub teams or workgroups

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Implementation Process

- Task Force
 - Develop the strategy (e.g. a plan of action)
 - Tactics – a procedure or set of maneuvers engaged in to achieve an end, aim or goal
 - A smooth transition will rely on an effective strategy and a well developed set of tactics.



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Implementation Process

Initial decisions

- Establishment of leadership (e.g. chairperson) to move the group towards the common goal and assists in overcoming obstacles.
- Address the critical factors of the implementation process
 - Formulating a plan, timeline and setting goals
 - Development of an education and training program
 - Setting routine meetings to assess progress and obstacles
 - Development of an ICD-10 Budget
 - Implementing post-implementation analysis and reporting

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Implementation Process

- Sub committees and workgroups
 - Cross-representation is required to ensure common goals and interdepartmental needs are met
 - When working with subgroups
 - Maintain the process of moving forward by keeping the meeting short and focused on the task at hand
 - Make sure the information is relative to the group
 - Develop an implementation plan with specific goals
 - Evaluate milestones periodically

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Implementation Process

- Tactical decisions
 - An impact analysis to identify:
 - Products, programs and forms requiring change
 - Software / hardware changes and updates
 - Changes to coverage determinations and policies
 - Schedule and timeline to work with vendors
 - Training and staff support
 - Maintenance and support for dual systems (I-9 & I-10)
 - Implementation and testing of the changes
 - How to roll out the changes
 - Project Goals

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Implementation Process

- Assess each area of the facility
- Define timelines and phases of implementation
 - Phase 1
 - Develop a task force
 - Begin preliminary education
 - Develop a communication plan
 - Designate IT / IS (Information Systems) team leaders
 - Evaluate process

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Implementation Process

- Phase II
 - Educate coders and Clinical staff
 - Develop budget (determine financial impact on facility)
 - Identify software and hardware changes/updates
 - Begin advanced education
 - Begin testing systems
 - Arrangements for additional staffing / support
 - Increase communication
 - Test the results of initial training

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Implementation Process

- Phase III
 - All systems should be tested and ready to go live
 - Contingency plans should be in place for failed systems
 - Communication systems should be in place and ongoing

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Implementation Process

- Phase IV
 - Post-implementation assessment
 - Assess and continue training and education
 - Review and monitor budget and cost reporting
 - Monitor and audit coding
 - Communication should be ongoing and in this phase is essential

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Implementation Process

- Budget Issues
 - Training and Education
 - Staffing and Overtime Costs
 - IT & IS
 - Communication
 - Line of credit
 - Productivity and reimbursement losses
 - Auditing and monitoring
 - Crosswalk and mapping costs

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Implementation Process

- Other Considerations
 - Education
 - Identify the type of education
 - Consultants, seminars, webinars, books, audio, etc.
 - Identify who requires training and at what level
 - Physicians, coders, billers, registration, authorization, etc.
 - Identify when to train
 - When considering the cost of education factor in the loss of productivity

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Implementation Process

- Other Considerations
 - Communication
 - Who or which committee is responsible to disseminate the information
 - Determine the form of communication
 - Email, newsletter, meetings, e-blasts
 - The frequency of communications
 - Monthly, weekly, etc.
 - Who will be addressed and which method of education will be most beneficial



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Learn More About It

- CMS has Developed Manuals to assist physicians and groups with the transition
 - https://www.cms.gov/ICD10/02b_Latest_News.asp#TopOfPage
 - Large Physician Groups
 - Small Physician Groups
 - Small Hospitals
 - Payers

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Learn More About It

- [Centers for Disease Control & Prevention](http://www.cdc.gov/nchs/icd/icd10cm.htm)
<http://www.cdc.gov/nchs/icd/icd10cm.htm>
- Centers for Medicare and Medicaid Services
<http://www.cms.gov/icd10/>
- World Health Organization
<http://www.who.int/aboutwho/en/mission.html>
- National Center for Vital and Health Statistics
<http://www.ncvhs.hhs.gov/>
Mappings/crosswalks
<http://www.cdc.gov/nchs/icd.htm>

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Summary

- It's only as difficult as you make it
 - Most providers utilize only a section of the ICD-10-CM manual
 - Most of the coding guidelines remained the same
 - Start early
 - Develop a Task Force
 - To develop crosswalks for common codes
 - To increase the specificity of documentation
 - Training
 - Implemented at the right time
 - Directed to the appropriate staff
 - Delivered at the appropriate level



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Future of Healthcare the Electronic Age



Presented By: Medco Consultants, Inc.
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This slide features a green header with the text "E-Prescribing" in white. In the top left corner is a circular logo for "mci MEDCO CONSULTANTS, INC." with the tagline "Medical Coding, Consulting & Compliance". The main content area is white and contains a bulleted list. The list starts with a main bullet point "Why should I E-prescribe?" followed by five sub-bullet points, each preceded by a dash.

- Why should I E-prescribe?
 - Saves Time
 - Improves patient safety and quality of care
 - There is a monetary incentive
 - The sooner you participate the greater your incentive
 - Beginning in 2012 if you are not a successful E-prescriber you will be subject to a payment adjustment



E-Prescribing

- What is the Medicare E-Prescribing Program?
 - An incentive program authorized under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
 - Provides incentives for eligible professionals who are “successful e-prescribers”
 - The program began on January 1, 2009
 - It is based on one E-prescribing quality measure #125 (removed from PQRI in 2009)
 - This will allow for two incentives (E-prescribing & PQRI)



E-Prescribing



- What is the incentive / payment adjustment ?
 - For 2011 e-prescribing incentive amounts will be 1% of the total estimated allowed charges for Professional Services covered by Part B Medicare
 - Starting 2012 – if you do not report a minimum of 10 e-prescribing reporting events during the six-month period of Jan. 1 to June 30, 2011. A penalty of 1% will be assessed for all allowed charges for Part B covered services during 2012.



E-Prescribing



- What is the incentive / payment adjustment?
 - The payment cut is estimated to be from \$2,000 to \$3,000 for the typical internal medicine practice.
 - Practices that do not report a minimum of at least 25 e-prescribing reporting events between Jan. 1 and Dec. 31, 2011 will be assessed a 1.5% penalty for all Medicare allowed charges submitted in 2013.



E-Prescribing

- Who is considered an eligible professional?
 - A successful E-Prescriber and those who are authorized under their respective state practice laws to prescribe
- What is a “successful E-prescriber”?
 - You must report the E-prescribing quality measure must generate and report one or more eRX with a patient visit, a minimum of 25 unique visits per year



E-Prescribing

- Are there other eligibility requirements?
 - Your estimated allowed Medicare Part B charges for the e-prescribing measure codes are at least 10% of their total Part B allowed charges.
 - E.G.- an eligible professional has \$100,000.00 in estimated Part B charges, at least \$10,000.00 of these charges must be based upon the HCPCS codes in the denominator of the E-prescribing Incentive Program
 - Examples of some denominator codes: 90801-90809, 92002, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315-99316, 99324-99328, 99334-99337, 99341-99345, 99347-99350, G0101, G0108, G0109



E-Prescribing

- Choosing A Qualified E-Prescribing System
- A system is qualified if it can:
 - Generate a complete active medication list incorporating electronic data received from pharmacies & pharmacy benefit managers
 - Select medications, print prescriptions, electronically transmit prescriptions and conduct alerts
 - Provide information related to lower cost, therapeutically appropriate alternatives (if any)



E-Prescribing

- Choosing A Qualified E-Prescribing System
- A system is qualified if it can:
 - Provide information on formulary or tiered formulary medications, patient eligibility and authorization requirements received electronically from the patient's drug plan.



E-Prescribing

- What is a “qualified system”?
 - *If the E-prescribing system is only capable of sending a fax directly from the E-prescribing system to the pharmacy, the system isn't a qualified E-prescribing system.*



E-Prescribing

- How to Report
 - When you have an applicable case the E-prescribing measure is reported in two steps
 - Bill for one of the denominator codes, e.g.

90801	90808	96150	99204	99215	G0101
90802	90809	96151	99205	99241	G0108
90804	92002	96152	99211	99242	G0109
90805	92004	99201	99212	99243	
90806	92012	99202	99213	99244	
90807	92014	99203	99214	99245	



E-Prescribing

- Step 2
- Report G Code - G8553 At least one prescription created during the encounter was generated and transmitted electronically using a qualified ERX system



E-Prescribing

- Avoid the 2012 penalty / payment adjustment
 - Not an eligible professional
 - Do not have prescribing privileges and utilizes G8644 Eligible professional does not have prescribing privileges
 - Does not have at least 100 cases containing an encounter code in the measure denominator
 - Does not meet the 10% denominator threshold
 - Meets and reports a significant hardship exemption



E-Prescribing

- Avoid the 2012 penalty / payment adjustment
 - Providers currently can only claim hardship from two exemption categories to avoid the penalty:
 - The physician or practice is in a rural area with limited Internet access; (G8642)
 - is in an area with limited available e-Rx compatible pharmacies (G8643)
 - Meets and reports a significant hardship exemption by November 1, 2011





E-Prescribing

- Proposed categories
 - Practices that plan to participate in the Electronic Health Records (EHR) Incentive program in 2011 but delayed buying an e-Rx system. (Example: The practice wanted to rely on the e-Rx technology of an EHR system, but the vendor software is not yet compliant.)
 - Providers who cannot e-prescribe due to state or federal law restrictions (Example: Physicians who largely prescribe narcotics, which are restricted from being electronically transmitted in some areas.)
 - Eligible professionals who do not prescribe often.
 - Certain physicians who prescribe frequently but only for ineligible types of visits. (Example: Surgeons.)



E-Prescribing

- In Summary
 - Effective January 1, 2009 CMS provides an incentive for successful e-prescribers
 - The sooner you participate the greater your incentive
 - The longer you wait, imposed a penalty
 - You need a qualified e-prescribing system to participate
 - Become familiar with the G code used for E-prescribing
 - No need to register for this program just begin utilizing the G code



E-Prescribing

- Learn more about it:

https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp



Physician Quality Reporting System (PQRS)





Physician Quality Reporting System (PQRS)

- What is PQRS?
 - Focuses on the measurement of quality of care determined by evidence-based measures developed by professionals
 - PQRS is a voluntary quality reporting program created in 2007 by The Centers for Medicare & Medicaid (CMS)
 - It offers a financial incentive for eligible professionals (EPs) who elect to participate



Physician Quality Reporting System (PQRS)

- What is PQRS?
- The program provides for the payment of up to 1% of the total allowed charges for covered Medicare Physician fee schedule services to eligible healthcare professionals who successfully report PQRS quality measure.
- The 1% PQRS payments are in addition to the e-prescribing incentive



Physician Quality Reporting System (PQRS)

- Preparing to Report
 - Establish a workflow that allows accurate identification of each denominator-eligible Part B Medicare claim
 - Ensure these claims are accurately coded using PQRS quality data codes (QDCs)
 - Coordinate with your software vendor/clearinghouse to be sure they can report all PQRS codes accurately on your behalf



Physician Quality Reporting System

- Steps to Report
 - Step One – determine if you are eligible
 - Step Two – determine which PQRS reporting option works best for your practice
 - Claims-based
 - Registry Based for individual measures or measures groups



Physician Quality Reporting System

- Steps to Report – Step Three
 - EPs choosing to report on individual measures need to select at least three measures to report on to qualify for the incentive bonus
 - EPs choosing to report measures groups need to select at least one measures group to report to qualify for the incentive bonus



Physician Quality Reporting System

- Steps to Report
 - Step Three – Review the measures list
 - https://www.cms.gov/PQRS/15_MeasuresCodes.asp#TopOfPage

#	Measure Title & Description	Measure Developer	Reporting Options
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%	NCQA	Claims, Registryb, EHRb, DM Measures Group, GPRO 1c, GPRO 1ic



Physician Quality Reporting System (PQRS)

- Additionally each measure will have a frequency requirement for each eligible patient seen during the reporting period
 - Report one time only
 - Once per procedure performed
 - Once for each acute episode of care per eligible patient
- Some measures include specific timeframes
 - Within 12 months
 - Most recent



Physician Quality Reporting System (PQRS)

- PQRS codes are mostly CPT Category II codes, however, temporary G codes (HCPCS) codes will be used where category II codes have not yet been developed
- PQRS measures may require modifiers
- There are four kinds of CPT II modifiers



Physician Quality Reporting System (PQRS)

- CPT II Modifiers
 - Are used to indicate that a service specified in the associated measure(s) was considered but, due to either medical, patient, or system circumstance(s) documented in the medical record, the service was not provided



Physician Quality Reporting System (PQRS)

- CPT II Modifiers
 - 1P Performance Measure Exclusion Modifier **due to Medical reasons**
 - E.g. Not indicated: Absence of organ or limb, Contraindicated: patient allergic history, potential adverse effect
 - 2P Performance Measure Exclusion Modifier **due to Patient reason**
 - Patient declined, Economic, social, or religious reason



Physician Quality Reporting System (PQRS)

- CPT II Modifiers
 - 3P Performance Measure Exclusion Modifier due to System reason
 - Resources to perform the services not available
 - Insurance coverage/payor related limitations
 - Other reasons attributable to health care delivery system



Physician Quality Reporting System (PQRS)

- CPT II Modifiers
 - 8P Performance Measure Reporting Modifier – action not performed, reason not otherwise specified



Physician Quality Reporting System (PQRS)

- Putting it all together

Measure #64 Asthma: Asthma Assessment


- Clinical scenario:

A 38 year old patient with known asthma is seen by the clinician for follow-up care. The clinician documents in the medical record the numeric frequency of daytime and nocturnal asthma symptoms.




Physician Quality Reporting System (PQRS)

Eligible Cases - Denominator	
Patients aged 5 through 40 years on date of encounter	ICD-9-CM Codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
<u>AND</u> Diagnosis of Asthma	
<u>AND</u> Patient encounter during reporting period	CPT Codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245



Physician Quality Reporting System (PQRS)

REPORTING OPTIONS	
<u>Successful Reporting & Performance</u> <i>Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)</i>	CPT II 1005F



Physician Quality Reporting System (PQRS)

OR

REPORTING OPTIONS	
<u>Successful Reporting & Excluded from Performance</u> There are no allowable performance exclusions for this measure	NONE



Physician Quality Reporting System (PQRS)

OR

REPORTING OPTIONS

Successful Reporting & Performance

Not Met

Asthma symptom frequency not evaluated, reason not otherwise specified

CPT II
1005F-8P



Physician Quality Reporting System (PQRS)

Appendix D: CMS-1500 Claim Example

Example of an individual NPI reporting on a single CMS-1500 claim. See <http://www.cms.gov/physicianquality/downloads/2011/04/0111.pdf> for more information.

21. Review applicable PQRS measures related to **AST** diagnosis (Di) listed in Item 21. Up to 8 Di's may be entered electronically.

24C. Procedures, Services, or Supplies – CPT/HCPCS. Modifier as needed.

QDC codes must be submitted with a line-item charge of \$0.00. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRS calculations.

Solo practitioner - Enter individual NPI here.

The patient was seen for an office visit (99213). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence.

- Measure #1 (CCL-C) with QDC 3846F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21).
- Measure #2 (BP in Diabetes) with QDCs 3074F + 3075F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21).
- Measure #3 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21).
- Measure #4 (Urinary Incontinence) - Urinary Incontinence with QDC 1809F. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.
- NPI placement: Item 24C (24C) contain the NPI of the individual provider that rendered the service when a group is billing. This includes putting the individual NPI on the QDC line-items as well.
- The Tax ID associated with the NPI(s) on this claim is shown in Item 25.

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PQRS

- Learn More About It

https://www.cms.gov/PQRS/03_How_To_Get_Started.asp



Electronic Health Records

- What you need to know
 - Is it compatible with my practice management software?
 - If not will it need an interface? What is the cost and time involved?
 - Does it meet meaningful use (HITECH) requirements



- Health Information Technology for Economic and Clinical Health Act (HITECH Act)?
 - legislation created to stimulate the adoption of electronic health records (EHR) and supporting technology in the United States.
 - President Obama signed HITECH into law on February 17, 2009
 - Part of the American Recovery and Reinvestment Act of 2009 (ARRA), an economic stimulus bill.



Electronic Health Records

- The Recovery Act specifies three main components of meaningful use in a nutshell:
 - the use of a certified EHR in a meaningful manner
 - the use of certified EHR technology for electronic exchange of health information to improve quality of health care
 - the use of certified EHR technology to submit clinical quality data and other measures to CMS.



Electronic Health records

- Incentives / Payment adjustment
- Physicians implementing an EHR and meet the specified requirements will receive up to five years of Medicare or Medicaid incentive payments.
- Feb. 29th 2012 is the last date that a physician can start to receive incentives and obtain the full five years of payments.



Electronic Health records

- Incentives / Payment Adjustment
- Significant reductions in Medicare payment will starting in 2015 to physicians who do not use an EHR or cannot demonstrate meaningful use
- Learn More About It

<http://www.cms.gov/ehrincentiveprograms/>



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Questions & Comments



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