The CMS ICD-10 Announcement: What It Means to Your Practice

First, the game-changing announcement below means that a sigh of relief is in order. Some of the anxiety surrounding potential financial disaster should be abated. CMS announced:

> *"Medicare review contractors [MACs and RACs] will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a* ***valid code from the right family****." (see FAQ2 below)*

Second, we think it means that the sword rattling coming from the AMA and other individuals should subside. The fact that the CMS changes are based on recommendations from the AMA, which has been adamantly opposed to the ICD-10 mandate for years, is no less unexpected than the lion laying down with the lamb.

Regardless of the changes, the AMA's previous assertion that ICD-10 "will create significant burdens on the practice of medicine with no direct benefit to individual patients' care" still stands. The transition is inevitable, in my mind, but the changes **will** lessen the burden on physicians.

In the announcement from CMS, the clarification was made that

> *"In accordance with the coming transition, the Medicare claims processing systems will not have the capability to*

> *accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.”*

Third, CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS’s ICD-10 Coordination Center.

Also, mark your calendars! CMS will have a provider call on August 27th to discuss these changes.

See the answers below provided by CMS in their new FAQs published this week.

Q1. What if I run into a problem with the transition to ICD-10 on or after October 1st 2015?

A1. CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS’s regional offices to address physicians’ concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman.

Q2. What happens if I use the wrong ICD-10 code, will my claim be denied?

A1. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review

or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

Q3. What happens if I use the wrong ICD-10 code for quality reporting? Will Medicare deny an informal review request?

A3. For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use 2 (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes. CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients, and the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes). CMS will continue to monitor the implementation and adjust the timeframe if needed.

Q4. What is advanced payment and how can I access this if needed?

A4. When the Part B Medicare Contractors are unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems, an advance payment may be available. An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 421.214 are met. To apply for an advance payment, the Medicare physician/supplier is required to submit the request to their appropriate Medicare Administrative Contractor (MAC). Should there be Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments. CMS does not have the authority to make advance payments in the case where a physician is unable to submit a valid claim for services rendered.

NOTE: *Watch for upcoming posts on ICD-10 websites and apps that I am rating for their usefulness. We will also be producing free webinars on translating the diagnoses on your superbills, picklists and cheat sheets for ICD-10 – stay tuned!*

Photo Credit: Tojosan via Compfight cc

AMA Updates Vaccine CPT Codes for 2012 – 2013 Use

As they have since 2006, the American Medical Association released updated CPT codes for vaccines last week ahead of the 2013 official code book release.

Some of the highlights of the semi-annual report:

- **Code 90653** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use"
- **Code 90739** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use"
- **Code 90672** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Influenza virus vaccine, quadrivalent, live, for intranasal use"
- **Codes 90685, 90686, 90687, 90688** were ACCEPTED for inclusion in the 2014 codebook production cycle
- **Codes 90655, 90656, 90657, 90658, and 90660** will include the term "trivalent", meaning "conferring immunity to three different pathogenic strains or species"

You can learn more about the changes for July 2012 at the AMA's Category I Vaccine Code Page

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Texas Medical Association Video: Grandma and the Big Bad SGR

I haven't written much about the impending 29% Medicare physician payment cut. This threatened cut has happened every year for the past 10 years. Every year at the last second, Washington is convinced that if cuts take place, physicians really will stop seeing Medicare patients and they halt the

cut.

It’s not a bluff. Physicians can’t afford to see Medicare patients, TriCare (ex-military) patients and disabled patients with Medicare benefits now, and they will drop out by the tens of thousands if they get paid any less. Any businessperson worth their salt will tell you that when revenue does not exceed expenses, you do not have a sustainable business model. Physician have cut expenses to the bone, taken deep cuts in their salaries and ultimately have sold their practices when they just can’t make it anymore.

But never mind the doctor, what about the patients? What happens to them when physicians stop seeing Medicare patients? **Texas Medical Association** has made an outstanding video that explains it in language we can all understand.

Other organizations that are working to eliminate physician reimbursement being tied to the SGR are **MGMA** and the **AMA**.

The Social Media Conversation

As social media matures and more healthcare groups gain experience using it, we understand more about it and the role it will play in the future of healthcare.

Last week, Abraham and I gave a program called “Starting the Conversation: An Introduction to Using Social Media In Healthcare” to a group of healthcare managers. We discussed social media’s potential to influence patient satisfaction,

which is expected to influence reimbursement.

You can download our program **here.**

Resources from the presentation:

AMA Social Media Guidelines
Ohio State Medical Association Social Media Policy
CDC Social Media Toolkit
Dose of Digital Wiki of Healthcare Communities and Websites
Pew Internet and American Life Project
Mayo Clinic Center for Social Media
Manage My Practice Social Media Posts
"Found in Cache" Social Media resources for health care professionals by Ed Bennett
Five Simple Rules for Social Business
Brian Solis Definition of Social Media

Coding for the Rest of Us: Why Everyone in Your Practice Needs a Basic Knowledge of Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact

that we are privileged to care for patients, but as the saying goes “No money, no mission.”

- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the **appropriate service and diagnosis codes.**
    - The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff **enters the payments and/or charges** if the service codes have not already been posted via the EMR.
    - The biller “scrubs” the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

“Coding” means two things: s**ervice codes** and **diagnosis codes**.

Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced "hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level

provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.
- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**
- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard

accompanying services.

- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

Other articles of interest:

How Many Staff Do You Need?

A Perfect Day in Your Medical Practice

Google PHR is Going Away – What Did We Learn?

The death of Google's Personal Health Record (PHR) should be a wake up call to everyone about electronic medical records (EMR) – **it's not a walk in the park**!

Granted, the fact that EMR is very complex software is not the only reason Google Health couldn't hack it. Many fine articles

and blogs point to under-marketing, an unrealistic reliance on consumers to enter data to complete their own records, unusually slow adoption by consumers, and a possibly unrealistic revenue model (selling data.) I'm pretty sure the readers of Manage My Practice could have predicted most of that, especially the part where consumers are not incentivized to enter their own health information.

Here's my advice to anyone who wants to capture the health data market:

1. Any personal health record must be **connected to my primary care provider**. I don't want my PHR to be freestanding from my PCP's (primary care physician/provider) EMR. Really wasteful.
2. I want someone I know and trust – maybe someone associated with my PCP – to **show me how to use and understand the information in my PHR.**
3. I want all my other physicians and test centers to **automatically send my records** to my PHR and for it to load without my participation.

Wow, that really sounds like my PHR is an offshoot of my PCP's EMR, doesn't it? Everyone sends the records to my PCP and my PCP gets the data into her EMR, then information feeds into my PHR in a format I can understand. Maybe my PHR resides in the practice's patient portal where it is protected and secure, but I can still get to it wherever I am.

Of course, my PCP is already overworked and underpaid, so this scenario isn't very realistic. Unless…a new HCPCS (Healthcare Common Procedure Coding System) service code is developed for "provider and patient load medical records together" and the insurance companies pay for it based on the fact that the more data the PCP has about the patient, the more customized and efficient the care can be. AMA, are you listening?

Photo credit: Mary Pat Whaley

ePrescribing Survivial Guide: Getting Your Ten Electronic Prescriptions Done in the Next 30 Days

Image via Wikipedia

This is a busy time for most practices. Managers are preparing for the annual juggling act of getting staff and physicians coordinated for summer vacations. Practices are ramping up for new doctors joining their practice at the traditional end of residency programs in the summer. Many practices are in the midst of shopping for, negotiating for or implementing EMRs. And most everyone without an existing EMR is struggling with the e-prescribing deadline looming in 30 days. Read my first post on this topic **here.**

As a reminder:

- Eligible professionals who are not successful e-prescribers, based on claims submitted between January 1, 2011 and June 30, 2011, may be subject to a "payment adjustment" (read payment cut) in their Medicare Part B Physician Fee Schedule (PFS) for covered professional

services in 2012.
- Those that do not e-prescribe as a part of 10 Medicare patient encounters by June 30, 2011 will only receive 99% of their Medicare payment for all encounters in 2012.
- Those that do not e-prescribe as a part of 25 encounters by December 31, 2011, will only receive 98.5% of their Medicare payments for all encounters in 2013 and only 98% of their Medicare payments for encounters during 2014 and going forward.

Here are the problems practices have encountered trying to get their ten:

- Physicians seeing patients in facilities and using the codes that are eligible for eRx, but not having the ability to e-prescribe during the visit
- Physicians in specialties not prescribing many medications
- Physicians in specialties prescribing predominantly controlled drugs, which are not currently eligible for electronic prescribing

Today, the AMA released this announcement

> ***May 31, 2011***
>
> *On May 26 the Center for Medicare and Medicaid Services (CMS) responded to AMA concerns about the e-prescribing penalty program and issued a proposed rule that makes significant changes to it by adding more exemption categories. These changes will assure that physicians are not unfairly penalized for failing to meet the requirements under the 2012 e-prescribing penalty program.*
>
> *Physicians are still required to e-prescribe using a*

qualifying e-prescribing system and report the G8553 code on at least 10 Medicare Part B claims from Jan. 1, 2011, through June 30, 2011, to avoid the 2012 e-prescribing penalty.

However, to avoid the 2012 e-prescribing penalty, physicians now ***will have an opportunity to attest through an on-line web portal that they are eligible for one of the following penalty exemptions****:*

- *Physician's practice is located in a rural area without high speed internet access*
- *Physician's practice is located in an area without sufficient available pharmacies for electronic prescribing*
- *Physician is registered to participate in the Medicare or Medicaid EHR Incentive Program and has adopted certified EHR technology* ***(New)***
- *Physician is unable to electronically prescribe due to local, State, or Federal law or Regulation (e.g., prescribes controlled substances)* ***(New)***
- *Physician infrequently prescribes (e.g., prescribe fewer than 10 prescriptions between January 1, 2011 –June 30, 2011)* ***(New)***
- *There are insufficient opportunities to report the e-prescribing measure due to program limitations (e.g., surgeons)* ***(New)***

Physicians will have to apply for an exemption from the 2012 e-prescribing penalty via the web-portal tool by Oct. 1.

What if you don't fall into one of these new categories?

It's time to tap into one of the free electronic prescribing packages available. Here are two choices:

1. **The National ePrescribing Patient Safety Initiative**

(NEPSI) – Free, Allscripts Software
2. **Practice Fusion** – Free, probably will have advertising and your data will be mined (all 10 prescriptions!) but you may be able to get it up and running very quickly

Some other thoughts on getting your ten done

1. Prescribe over-the-counter drugs including stool softeners and anti-emetics.
2. Prescribe Tylenol3 or another non-controlled pain reliever – patients do not need to pick these prescriptions up or pay for them.
3. Ask your Medicare patients if they have any prescriptions they would like you to refill while they are in the office. Over-the-phone refills do not count as there is no associated face-to-face service.

White Coat Wednesday: Call Congress November 17th to Protest the Medicare Physician Cuts

Please call the AMA Grassroots Hotline, and have **everyone** in your office/department/building/campus call the Hotline on

Wednesday, November 17th (White Coat Wednesday) and every day thereafter until November 30th to insist that Congress vote for the 13-month patch to the SGR formula.

AMA's toll-free Grassroots Hotline – 1.800.833.6354

AMA website discussing the issues here.

AMA flyer to post in your office here.

House Bill Would Delay June 1, 2010 Medicare Cuts to 2014 and Provide Modest Increases In Between

UPDATE: On June 24, 2010 the House and Senate passed legislation to further delay the Medicare cuts until November 30, 2010. **More here.**

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Article by David Glendinning at amednews.com **here.**