# ICD-10 Implementation Strategies for Physicians – My Notes from the CMS Provider Call

The new winner of my ongoing competition for the CMS Employee Speaker contest is Dr. Daniel Duvall, Medical Officer, Hospital and Ambulatory Policy Group Center for Medicare! During a recent ICD-10 call, Dr. Duvall spoke clearly, was easy to understand and kept my attention.

## Why are we moving to ICD-10?

ICD-9 has deficiencies, such as:

- Not enough detail for analyzing diseases
- Not enough detail for payment
- Insufficient attention to:
  - Medical encounters for reasons other than death
  - Non-lethal manifestations
- Out of room for new codes
- Obsolete family groups
- Unable to address 30 years of medical knowledge of etiology
- Inadequate attention to continuum of disease and clinically relevant subsets

## ICD-10 brings to the table:

- Appropriate payment via stratification of morbidity (“My

patients are sicker")

- Specificity needed for episodes of care, Affordable Care Organizations, Hierarchical Condition Categories, and quality monitoring
- Better quality in research/clinical trials
- Identification of consistent cohorts
- Improved outcomes from population analysis
- Targeting resources to diseases: specialty, county, environment
- 2010 computational power cannot use 1980's information

**The detail is demanded not by government nor by payers but by specialty societies.**

# What exactly is ICD-10?

- Stands for International Classification of Diseases
- Developed by World Health Organization (WHO)
- The order of chapters is just like ICD-9
- Was originally released in 1993 and adopted by other countries
- Approximately 2000 diseases (families)
- Approximately 70,000 specific codes
- ICD-10-CM (diagnoses) will be used by all providers in every health care setting
- ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
- ICD-10-PCS will not be used on physician claims, even those for inpatient visits (procedure coding system)

# Will ICD-10 change the use of CPT and HCPCS?

There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes – CPT and HCPCS will continue to be used for physician

and ambulatory services including physician visits to inpatient.

## How much of a headache will ICD-10 really be?

Dr. Duvall characterized how difficult the transition to ICD-10 will be for each stakeholder group, by assigning them stars and headache types. The more stars, the more head-pounding the transition will be!

- Government, CMS & CDC will have 5-star headaches (encephalitis)
- Health Insurance Plans will have four-star headaches (migraine)
- Hospitals will have three-star headaches (cluster)
- Billing Agencies will have two-star headaches (sinus)
- Physicians will have one-star headaches (tension)

## What should practices be doing now to prepare?

- Create a new job aid (cheat sheet) or superbill
- Update proprietary software or contact billing software vendor to discuss changes
- Train your coders and billers
- **Train your physicians and providers**
- Purchase new coding books and forms
- Develop a conversion plan –
  - Paper Charts
  - EMR
  - For some small conversion projects it may well be quicker and more accurate to use ICD-10 code books

instead of GEMs (crosswalks)

## When will the change to ICD-10 happen?

- **Single implementation date of October 1, 2013 for all users**
- Ambulatory and physician services provided on or after 10-1-2013 will use ICD-10-CM diagnosis codes
- Inpatient discharges occurring on or after 10-1-2013 will use ICD-10-CM and ICD-10-PCS code
- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013
- ICD-10 codes will not be accepted for services prior to October 1, 2013
- Last regular, annual updates to both ICD-9-CM and ICD-10 will be made on October 1, 2011
- On October 1, 2012 there will be only limited code updates to both ICD-9-CM & ICD-10 code sets to capture new technology and new diseases
- On October 1, 2013 there will be only limited code updates to ICD-10 code sets to capture new technology and new diseases
- There will be no updates to ICD-9-CM on October 1, 2013 as the system will no longer be a HIPAA standard
- On October 1, 2014 regular updates to ICD-10 will begin

## Q & A (my favorite!)

***Q: What will the financial impact be for a small practice to implement ICD-10?***

A: This is dependent on how claims are being submitted and if the practice is responsible for paying for the system upgrade to handle ICD-10. If you are using free electronic billing,

there should be minimal financial impact.

***Q: Is the cost to the American public worth the value ICD-10 is supposed to create? Also, will offices be required to "prove" the new codes by sending medical records to payers?***

A: Dr. Duvall answers "Yes" to the first question. As to the next question, that process is related to new codes moving from experimental to actual, not the process of moving from ICD-9 to ICD-10. Payers will not be requesting mass medical records since the change is global.

***Q: With 2 years to go, when should we start training the staff?***

A: You should start training 6-9 months before October 2013.

***Q: There will be a tremendous impact on practices where physicians have not been documenting appropriately as there will not be enough information to choose a code. You are minimizing the physician's time and effort needed to make this change.***

A: Anyone who has been documenting correctly will have a relatively easy time choosing an ICD-10 code. Anyone who has been documenting minimally will have a hard time.

***Q: What format will the new codes be released in?***

A: They are in pdfs now, and they are also available in text and html formats.

**Q: What will commercial payers be using for ICD-10?**

A: Payers might be using GEMS (General Equivalence Mappings) to map from ICD-10 to ICD-9 if they are not ready.

## Resources

General Equivalence Mappings (GEMs) assist in converting data from ICD-9-CM to ICD-10
Forward and backward mappings – **Information on GEMs and their use** – (click on ICD-10-CM or ICD-10- PCS to find most recent GEMs)

The CMS Sponsored ICD-10 Teleconferences **web page** provides information on upcoming and previous CMS ICD-10 National Provider Calls, including registration, presentation materials, podcasts, video slideshow presentations, written transcripts, and audio recordings http://www.cms.gov/ICD10/Tel10/list.asp

**Provider Resources** (for all providers) http://www.cms.gov/ICD10/05a_ProviderResources.asp

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# Medicare Releases New Product-Specific HCPCS Codes for Flu Shots Billed After January 1, 2011

## NOTE: The 2012 – 2013 flu shot codes can be found here.

## For flu shot updates for the 2011-2012 influenza season, click here.

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## Changes in Flu Shot Codes When Billing On/After January 1, 2011

CMS has created specific HCPCS codes and payment allowances to replace CPT code 90658 for Medicare billing purposes for the 2010-2011 influenza season. Note that these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when **CPT code 90658 will no longer be recognized.**

- Q2035 (locally priced)
  - **Afluria** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
- Q2036 ($7.439 national allowable)
  - **Flulaval** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
- Q2037 ($13.253 national allowable)
  - **Fluvirin** vacc, 3 yrs & >,im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
- Q2038 ($12.593 national allowable)
  - **Fluzone** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 (locally priced)

- **NOS** flu vacc, 3 yrs >, im
    - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

## Other information:

- For dates of service between October 1, 2010 and December 31, 2010, the CPT 90658 and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the CPT 90658 and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010 and December 31, 2010, the provider may either bill Medicare immediately using CPT 90658, or hold the claim and wait until January 1, 2011 to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using CPT 90658, then there is no need to use the Q-code for that same service. For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.
- For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for CPT 90655 is $14.858.
- Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination

must take assignment on the claim for the vaccine.

- Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR7324. However, they will adjust such claims that you bring to their attention.

For additional information on providing the flu shot, see my previous post **here**.

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# The Cohen Report: Medicare Part B NCCI Update 16.2 for Providers Effective July 1, 2010

Here's your pop quiz:

The NCCI edits are:

A. pairs of services that should not be billed by the same physician for the same patient on the same day.

B. definition refinements for HCPCS codes.

C. diagnosis codes (ICD-9) that cannot be billed together on a CMS 1500 claim.

The answer is below the picture.

Image by sxyblkmn via Flickr

If you answered “A”, you’re on top of your game!  The King of the National Correct Coding Initiative (NCCI) quarterly analysis is Mr. Frank Cohen and he provides that analysis free of charge for all.  Thank you, Frank!  With his analysis, you have the opportunity to see what’s changed and what’s new, to tweak your system to catch the pairs, and to make sure you are providing the right care at the right time as well as maximizing your reimbursement.

## The Cohen Report:

In summary, there are 16,843 new edit pairs, bringing the total number of active edit pairs to 653,718. Six of these are backdated to an effective date of January 1, 2010. The majority of these (75.17%)  are associated to the edit policy “Misuse of column two code with column one code”� with 12.82% associated to “Standard preparation / monitoring services for anesthesia”�. There are 6,042 unique Column 1 codes and 274 unique Column 2 Codes within the new edits.

There are 36 new terminated edit pairs with 12 backdated to January 1, 2010 and two backdated to April 1, 2010. The edit policies associated to these edit pairs are distributed between “Misuse of column two code with column one code”� (44.4%), “CPT Manual and CMS coding manual instructions”� (33.3%) and “More extensive procedure”� (22.2%).
There were 413 edit pairs with modifier changes. Of these, 387 went from 0 (no modifier permitted) to 1 (modifier permitted) and 26 went from an indicator of 0 to an indicator of 1.
There are currently 1,336 duplicate entries; codes that were activated at one point then terminated and then re-activated. There are 5,318 swapped edit pairs; situations where the edit pair was introduced at one point in a specific order (column 1 and column 2), terminated and then re-

activated with the edit pair in the opposite order.

I have posted my analysis worksheets for those interested in the details. Go to www.frankcohen.com and click on the Download tab.ï»¿