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FEATURED ARTICLE

By Ardith Campbell, CPC, CPC-H, CCP

On the Road to ICD-10: ICD-10 Diagnostic Coding System

LIKE FOLLOWING A ROADMAP OR listening to the monotone voice of your car's GPS system, this article will give you glimpse into the major changes that are going to affect the International Classification of Diseases, 9th Revision, Clinical Module (ICD-9-CM) as we get ready to move to the 10th revision, or ICD-10.

In order to have an appreciation for what's up the road ahead, we need to know the major differences between the I-9 and I-10 diagnosis coding systems and to understand how these changes may affect your position and that of your provider. As you probably already know, although it is worth repeating, the Centers for Medicare & Medicaid Services (CMS) has considerable information on its website about I-10. Both AAPC and AHIMA are also doing a great job on providing information regarding the upcoming changes.

In the Beginning

Knowing the history will help us understand why we need to make such sweeping changes in the ICD system. The World Health Organization (WHO) developed the ICD system for worldwide use. The WHO allows countries to make modifications, and the CM for clinical modification indicates that this is the version used by the United States. For example, ICD-10-AU is the Australian version. This allows for spelling variances (think orthopedic) and such.

The U.S. adopted the 9th revision in 1979, which expanded the diagnosis codes. Remember, diagnosis codes are Volumes I & II. This also established the ICD procedure coding system, or Volume III.

Of course, the Health Insurance Portability and Accountability Act, or HIPAA, designated the ICD system as a standardized code set. This established the diagnosis codes: Volumes I & II, for professional and facility use. Volume III was established to code procedures designated for inpatient facility claims.

HIPAA language also established the appropriateness of future versions of the code sets. Originally, it was thought that the ICD-10 procedure coding system (PCS) would be used instead of CPT/HCPCS, but that won't be the case. CPT and HCPCS codes will still be used for professional and outpatient hospital claims.

Sneak Preview

Just to give you a peek at the changes that will face you in the ICD-10 procedure coding system, the ICD-9 procedure codes are three to four digits. Many of the codes don't distinguish between an open approach and a closed approach.

An example given by CMS is Code 39.50, angioplasty or atherectomy of other non-coronary vessel(s). This is a very generic code. Is it open, percutaneous? Where in the body is the procedure located? Brachiocephalic, iliac? This one ICD-9 code will be replaced by 1,170 ICD-10 codes.

How many ICD-9 codes currently exist? There are approximately 14,000 diagnosis codes and just fewer than 4,000 procedure codes. Within the I-9 system, we are running out of room. There are some sections that are completely full and an update is greatly needed.

What about I-10? There are almost 155,000 codes. The diagnosis codes are expanding from 14,000 to 68,000 codes. The inpatient coders will go from 4,000 to about 87,000 codes. That's more than 80,000 more codes for the inpatient coders. But remember – the professional claims and outpatient hospital claims will still use the CPT/HCPCS coding systems.

The ICD-9 diagnosis codes currently have three to five digits. Chapters 1-17 begin with numbers, and then there are the V & E codes in the supplemental chapters. The diagnosis coding system is to be used by all providers, so whether you work on the physician side or for a hospital, these changes are going to apply to you.

Sign Posts for Code Changes

By way of example, here are a few codes to give you a greater appreciation for the changes that lie ahead:

- Code 311, depression, may be something we experience just thinking about this transition to I-10.
- Code 250.32, diabetic coma, may be something we experience after eating enough chocolate to make us feel better.
- Code E916 might be assigned if we suffer from Wile E. Coyote syndrome. After we've been hit on the head by a

falling object and walk around sounding like an accordion, we may have this E code assigned.

For the ICD-10 diagnosis codes, there will still be those that are only three digits, but there will be the possibility of expanding to seven digits. The first digit is alpha, and the following digits could be alpha or numeric. The alpha characters are case insensitive, which means that it won't matter if you use upper case or lower case. When you're attending training sessions, and you see that the first alpha is upper case and the rest are lower case, it really doesn't matter.

Using alpha characters as the beginning will allow for expansion. The beginning character will change from 12 to 26 right off the bat.

ICD-10 Diagnosis Codes

Some examples of the new ICD-10 diagnosis codes include J32.0, chronic maxillary sinusitis. Notice that this diagnosis code is specific to the sinus cavity. There are different diagnosis codes for ethmoid sinusitis, frontal sinusitis and more. The specificity of the diagnosis codes might require that some of you will need to brush up on medical terminology or maybe even anatomy and physiology.

Code L89.131, pressure ulcer of right lower back, stage I, takes the place of two ICD-9 diagnosis codes. There will still be instances when two diagnosis codes may be needed, but the instructional notes in ICD-10 will clearly spell these out.

Another example given by CMS to show the expansion of ICD-10 is the I-9 Code 996.1 mechanical complication of other vascular device, implant and grafts. This is a very general diagnosis and isn't very specific, is it? This one diagnosis code, however, will expand to 156 different diagnosis codes. For example, T82.322, displacement of femoral arterial graft (bypass), becomes very specific as to the location, and that it is a graft, rather than a device or implant.

Let's take a look at some of the changes we'll see in the diagnosis area.
There are both general and chapter-specific guidelines. Be sure to review the new guidelines for changes, because there are some major differences. The guidelines are already available for free on the CMS website.

> **If the code is going to require a seventh digit, but only has five, then an X will be used as a placeholder.**

One of the major changes is the instruction that says chapter- specific guidelines will take precedence over the general guidelines.

But there's a new twist on digits. There is a placeholder for some of the diagnosis codes. If the code is going to require a seventh digit, but only has five, then an X will be used as a placeholder. I know this will seem somewhat unusual for us.

Look What's New

Another new concept for us will be two types of "excludes" notes. Excludes Type 1 means that the condition is not coded in this section. What do I mean by that? The two codes should never be used at the same time. The example given in the guidelines is that an acquired condition and a congenital condition would never be coded at the same time.

Type 2 notes indicate that the condition is not included in this section. In this instance, the excluded condition isn't a part of the code and may be coded separately.

For syndromes, follow the alphabetic index for guidelines. If the syndrome is missing from the index, then you can assign the codes for the documented manifestations. This is a distinct difference from the "don't guide from the index" instructions we are accustomed to following.

The ICD-10 PCS system follows different conventions, where the digits have a specific function. About the only similarity is that they both have "placeholders."
At the beginning of each chapter, the book shows a breakdown of the sections. This will also be where you will see any Excludes1 or Excludes2 notes and details on the seventh digit. While the codes will begin with an alpha character, digits three to seven could be alpha or numeric.

Some of the common seventh digits include A for the initial encounter, D for subsequent encounter and S for sequela (late effects).

As an example, Chapter 4, Endocrine, Nutritional and Metabolic Diseases (E00–E99), provides guidance on the types of diabetes. The discussion even includes what to code if there is an unspecified diagnosis, which would be E11-. We may need to be careful when we first start out, and especially if we are relying on handwritten notes. Will this look like E one-one or E ell-ell?

While we're coping with that particular issue, there is assistance. Additional notes state that you can code from the E11 series and to use Z79.4 long-term use of insulin. Written guidance states that Code Z79.4 is not to be used if insulin is utilized as a short-term solution to gain control of the diabetes. There are notes stating that gestational diabetes is coded in the pregnancy chapter, and guidance is given for secondary diabetes.

Coding for Pregnancy, Childbirth

We've really just brushed the surface, but let's begin to dig a little deeper to see more of what is in store for us.

Let's look at Chapter 15, Pregnancy, Childbirth and Puerperium, with a code range from O00 to 099. I selected this chapter first because you begin to see that there may be some challenges. The diagnosis coding system uses zeroes and ones, as well as the letters o (oh) and L (ell). There may be challenges distinguishing between some of the alpha and numeric characters, particularly as we're beginning to learn the new system.

One excellent improvement in the I-10 manual is the notes. Chapter 15 starts with the stringent warning that codes from this section are only used for the mother and not for the baby.

The next point identifies that the codes in this chapter are for use in conditions related to or aggravated by the pregnancy, childbirth or puerperium.

Guidance is given regarding the trimesters and when to count them by using the date of the last menstrual period (LMP). Your first trimester is considered less than 14 weeks and zero days, and then your second trimester is from 14 weeks/zero days, etc. This information is located in the I-10 book and will be right at your fingertips.

Remember how excludes notes were mentioned earlier? Here are some examples.

> **The Excludes1 note** – remember, this means the condition isn't coded here. Almost like an "Oh, no you don't!" For example, supervision of normal pregnancy is in the Z34 range and you shouldn't be coding a normal pregnancy along with codes from this chapter.

> **The Excludes2 note** – meaning the condition is not included here and may be coded in addition to the diagnosis from Chapter 15. A few examples of these would be mental and behavioral disorders associated with the puerperium, or your postpartum depression would be found in the F53 section.

Earlier in this article, under "Look What's New," I discussed sequencing and how the chapter notes could take precedence over the general guidelines in certain circumstances. This next section provides an example. The I-10 manual states that codes O00-O09A have priority over other chapters. The final character identifies the trimester. For reporting hospital encounters that span trimesters, the manual also provides guidance. Be sure to read the guidelines to become familiar with them if you use maternity codes. And to report the outcome of the delivery, then Code Z37 can be used.

Let's take a look at one of the diagnosis codes. Code O009, supervision of elderly primigravida and multigravida, includes guidance on what is considered an elderly gravid patient, which would be a female 35 years or older.

Code O09.511, supervision of elderly primigravida, first trimester is for ladies who are having their first baby at age 35 or older. Note Code O09.519 may be used if the trimester is unspecified. So, although ICD-10 has much greater specificity, the unspecified codes still exist.

There are some codes for a 'young' primigravida and multigravida. Again, instructions give us the definition of young as less than 16 years old at the expected delivery date. Code O09.611 is for the supervision of young primigravida, first trimester and the last digit of 9 is for an unspecified trimester.

Code O09.62 is to report the young ladies who are having more than one baby. Note, the same last digits are used to report the trimesters.

Some interesting codes that provide examples of new technology include Code O09.81, supervision of pregnancy resulting from assisted reproductive technology. For instance, Code O09.82 is the supervision of pregnancy with history of in utero procedure during previous pregnancy.

If mothers have high blood pressure before becoming pregnant, Code O010, pre-existing hypertension complicating pregnancy, childbirth and puerperium, has an includes note with pre-existing proteinuria, and an Excludes2 note stating for those patients with increased or superimposed proteinuria would be coded in section O11. Code O11 may be interesting, as you'll want to make sure that you're able to distinguish the ones and not the letter L.

Code O24 is for diabetes reporting, but there are a few different codes where you will want to watch. Code O24.0 is for pre-existing type 1 diabetes mellitus, while Code O24.1 is for pre-existing type 2 diabetes. Does the mother have gestational diabetes? If so, Code O24.4 can be used. There are additional digits that can be used to specify whether the diabetes is diet or insulin controlled.

There are several new codes for reporting abnormal findings for antenatal screenings done on the mother. For example, we have Code O28.0, abnormal hematological findings, while Code O28.3, for abnormal ultrasound findings, or O28.4, for abnormal radiological findings. Notice that we have Code O28.8 for other abnormal findings and O28.9 for unspecified findings.

What is the difference between "other" diagnosis codes versus "unspecified" diagnosis codes? If the provider has documentation for a diagnosis, but no specific diagnosis exists, then you would have an "other specified" diagnosis. If the documentation doesn't identify the diagnosis, then you would have an "unspecified" diagnosis.

Here is another example of the use of "x" as a placeholder to indicate toxic reactions to local anesthesia during pregnancy – O29.3x1 Toxic reaction to local anesthesia during pregnancy, first trimester, etc.

Code O31, complications specific to multiple gestation, have an Excludes2 note which allows for conditions to be coded separately. For example, delayed delivery of second twin, triplet (O63.2), has a specific diagnosis in the ICD-10 system.

Code O31 has a seventh digit that represents the baby. Zero is for a single gestation, or an unspecified multiple. The instructions indicate that a code from O30 multiple gestation must be assigned when using Code O31, complications specific to multiple gestation. Again, these will go out to the seventh digit, and an x is used as a placeholder.

If the provider has documentation for a diagnosis, but no specific diagnosis exists, then you would have an "other specified" diagnosis. If the documentation doesn't identify the diagnosis, then you would have an "unspecified" diagnosis.

Here's a list of the seventh digits used in this section. Think Octomom, and you'll get an idea of how it would work:

0 Not applicable or unspecified
1 Fetus 1
2 Fetus 2
3 Fetus 3
4 Fetus 4
5 Fetus 5
9 Other fetus

Coding Diseases of Musculoskeletal

Let's move to another chapter. Chapter 13, Diseases of the Musculoskeletal System and Connective Tissue, is assigned to Codes M00–M99. The site of the disease represents either the bone, joint or muscle involved. This can be a little tricky when more than one bone, joint or muscle is involved, such as osteoarthritis. Lucky for us, a multiple sites code is available.

If the condition is related to bone, code the bone condition. What does that really mean? As an example, osteoporosis is coded in the M80 & M81 section. Osteoporosis may have joint involvement or be located close to a joint, but is considered a bone condition and should be coded as such.

The seventh digit specificity is important to this section, or should we say seventh character since specificity is important to this area as the last digit could be a letter. The last letter A is used for an initial encounter. This should be used as long as the patient is receiving active treatment, such as the emergency department encounter, surgical treatment, etc. The seventh character D, subsequent encounter, is for subsequent encounters.

When the hospital treats the patient, the visit would be coded with the seventh character A. When the patient goes to the ortho doctor a week later, the ortho doc would also use the seventh character A for the first visit and then D for the subsequent visits. Now, if there are late effects, then the seventh character S would be used.

For our bone codes, there is an Excludes2 note – and that means these conditions are not coded in this section. This is a nice list, so you can see that it may take a bit to become comfortable with the look and feel of the I-10 codes.

There are different "blocks" of codes within the chapter… M15–M19 osteoarthitis, M26–M27 dentofacial anomalies, M60–M63 disorders of muscles, and M80–M85 disorders of bone density and structure.

There are different "blocks" of codes within the chapter, and some examples of these are M15–M19 osteoarthitis, M26–M27 dentofacial anomalies, M60–M63 disorders of muscles, and M80–M85 disorders of bone density and structure.

Category M05, rheumatoid arthritis with rheumatoid factor, has an Excludes1 note – indicating the condition is not coded here – and includes rheumatic fever (I00 – eye zero zero). This example will help remind you that a handwritten physician's prescription with the rheumatic fever diagnosis may be a bit of a headache and an obstacle that you might face. Of course, if everything is printed out through an electronic medical record (EMR) system, it may not be as much of an issue for you.

Here is an example of the specificity we'll have with the I-10 codes. Felty's syndrome is defined by the presence of three conditions: rheumatoid arthritis, an enlarged spleen, and an abnormally low white blood count.

> M05.011 will specify the right shoulder, while M05.12 will specify the left shoulder. If the provider doesn't specify which shoulder, then we'll still have an unspecified code we can use. Code M05.02 is provided to show that there is a different code for elbows, and more.

Back in Oct. 2009, there were some ICD-9 updates that added a couple of codes for chronic gouty arthropathy with or without tophi. There is an explosion of codes to report where the gout is located. Instructional notes indicate it is appropriate to code additional disorders.

Currently there are additional codes to indicate the presence of tophi. In I-10, seventh digit specificity will indicate with or without tophi. For example, M1a.0 is for Idiopathic chronic gout.

The base code of M1a.1, is lead-induced chronic gout. If the site is not specified, then Code M1a.10 is available. Code M1a.11 provides additional specificity to the site, such as Code M1a.111 for the right shoulder. If the sixth character is 9, then the shoulder is unspecified.

Codes for Injury, Poisoning

Chapter 19 is the injury, poisoning and certain other consequences of external causes chapter, and the codes involved are in the range S00–T98. You will also want to include the secondary diagnosis from Chapter 20, external causes of morbidity.

There are some codes, however, within the T section that already include the external cause and wouldn't require the additional code from Chapter 20. Be careful when assigning codes from this section due to this ambiguity.

Some of the exclusions include birth trauma or obstetric trauma, because those codes are located in another section.

To break these down a little bit, think of S codes as single body regions and T codes for unspecified body regions, poisoning and other external causes.

As an example, let's review Code S00.0, superficial injury of scalp. Some of the superficial injuries listed include an abrasion, a nonthermal blister or even a bite. Code S00.06 is for an insect bite, but S00.07 shows an excludes note for an open bite of the scalp, and provides guidance where this other code is located.

Code S11, open wound of neck, also states you should code any associated injury, like a spinal cord injury or wound infection. For example, if there has been an accident with a steak knife, there would be a different diagnosis if the steak knife has broken off and is lodged in the neck, necessitating the need for using the "foreign body" diagnosis.

Another interesting code is W45.1, paper entering through skin, such as a paper cut. Yes, paper cut is in the manual.

S11.02	With additional specificity for laceration or puncture wounds, and with or without foreign body
S11.015	Open bite of the larynx, also includes bite of the larynx not otherwise specified
S11.021	Laceration without foreign body of trachea
S11.022	Laceration with foreign body of trachea
S11.023	Puncture wound without foreign body of trachea
S11.024	Puncture wound with foreign body of trachea

Instructions also state that a seventh digit should be added. This would include A for the initial encounter, D for subsequent encounters, etc.

Code S22 is for a fracture of the ribs, sternum and thoracic spine. Besides the ones we've listed before, there are digits such as G for subsequent encounter for fracture with delayed healing or K for subsequent encounter for fracture with nonunion. Guidance is given that if the fracture isn't specified as open or closed, then you should code it as a closed fracture.

External Causes

Chapter 20 is the external causes chapter, with the code range Y00–Y99. Or, why did this happen? This allows the capture of data to capture the circumstances or causes of the injury. While these should be coded secondary to S or T codes, they can really be secondary to any other chapters.

Transport Accident and Other Miscellaneous Codes

Transport accidents V00–V99 (v = vehicle) is broken into 12 sections. When I attended my first Webinar on I-10, one of the codes supplied during the training session was V86.01, driver of ambulance or fire engine injured in traffic accident. There is also Code V86.41 for a person injured while boarding or alighting from ambulance or fire engine.

For those dreaming of snow right now, Code V86.42, person injured getting off or on a snowmobile, is available. All of these will require seventh digit.

Slipping, tripping, stumbling, falls code to W00–W19 (w = watch out!)

For some examples we have W39 discharge of firework, for those Fourth of July accidents. Another interesting code is W45.1, paper entering through skin, such as a paper cut. Yes, paper cut is in the manual, I didn't have to make that one up!

In Closing

During our journey we covered considerable territory – we reviewed the history of ICD-10, took a high level look at the codes, and then dug a little deeper into the codes themselves.

We are reminded that "a journey of a thousand miles begins beneath one's feet," as the Chinese philosopher and author Lao-tzu once admonished, emphasizing the need for action.

ICD-10 beckons.

About the Author

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By Denise M. Nash MD, CCS, CIM

RACs Move into Medicaid: Are You Ready?

HAVE YOU HAD ENOUGH, ARE YOU ready for more? As you know there are many mandates in the document that President Obama signed back on March 23, 2010. Yes, that law, the Patient Protection and Affordable Care Act (PPACA), contains amongst many things the expansion of the ever-popular RAC program to Medicaid.

I can just feel the cheers out there from all of you. But enough of the jubilation! Section 6411 of the Act requires state and federal agencies to institute RAC audits for Medicaid, Medicare Part C (Medicare Advantage plans) and Medicare Part D (prescription drug plans) by Dec. 31, 2010.

Included in the mandate is an adequate appeal plan, suggesting that maybe something was learned from the Medicare project after all. It also says states must establish programs to contract with one or more Recovery Audit Contractors (RACs) for the purpose of identifying underpayments and overpayments and recouping Medicaid overpayments including in state waiver plans. (I wonder if all the RACs are familiar with all the different CPT/ICD-9 guidelines by state. This is something to ponder as these are not national standard guidelines, and one size does not fit all 50 states.)

Much like the Medicare RAC, payments will be made to contractors only on amounts recovered and will be issued on a contingent basis. Individual states may specify the contractor contingency fees for overpayments and underpayments. In President Obama's words, the goal of the increased audits is to "save at least $2 billion from expanded use of the audits over the next three years."

On the Bright Side

I know you don't think so, but is there a bright side to RAC expansion to Medicaid? Each state must have an appeal process in place and coordinate recovery efforts with "other contractors or entities performing audits," plus federal and state law enforcement agencies. Honestly, did you not think this was coming? The Medicaid Integrity Contractors (MIC), part of the Medicaid Integrity Program (MIP) under Deficit Reduction Act (DRA), which was signed in 2005, has not shown any financial results in recoupment. However, as taxpayers, we contributed $105 million in FY 2008 and $75 million in FY 2009 for the program. Good to know where my hard earned tax dollars are going!

MIC auditors can "look back" at accounts older than three years (the time period is state-specific); they have no record limits and they only have to give you two weeks to prepare what could be hundreds of accounts for review. The MIC also can review accounts that previously have been reviewed or authorized by another entity. Since the RAC Medicaid program is paid on a contingency, it is very likely that contracting entities will be auditing very aggressively.

The act also mandates expansion of the RAC program to Medicare Parts C and D. RACs are required to be under contract to ensure that every Medicare Advantage plan under Part C and every prescription drug plan under Part D has an anti-fraud plan in place. The anti-fraud plans must be reviewed along with the prescription drug plans' estimates of enrollment of high-cost beneficiaries compared to actual numbers of such beneficiaries. Many denials seen with the RAC audits involve allegations of lacking medical necessity. The high overturn rate in the Medicare appeals process is a testament to the inappropriateness of many of these denials.

Deadline Looms Ahead

Will the Dec. 31 deadline be met? This new initiative for Medicaid may not be as easy because it means coordination of 50 state programs. During the Senate Homeland Security and Governmental Affairs subcommittee on Federal Financial Management, Government Information, Federal Services and International Security hearing convened on July 14, 2010, Deborah Taylor, director and chief financial officer for CMS Office of Financial Management, testified, "We are still in the planning stages. We're looking a little harder at Medicaid [because] it's going to be tougher for us." Ms. Taylor did report that the agency is further along in its implementation of the RAC Medicare Part D prescription drug program.

As an aside, the RAC executives were also present at the hearing and testified. Are you ready for this? They said they welcomed the additional workload and would be ready to work with CMS on expanding the program. Surprise!

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TALKING POINTS

By Jamelyn Bibbins, RN, BSN, MPA, CPC-H

FY 2011 IPPS Final Rule: Good News, Not So Good News

GOOD NEWS AND NOT SO GOOD news – much of it driven by healthcare reform legislation – has been bundled into the Inpatient Prospective Payment (IPPS) Final Rule for FY 2011 from The Centers for Medicare & Medicaid Services (CMS) and is now available for review in the Federal Register.

Listed below are a few highlights that should be of particular interest to those who work in acute care hospitals.

IPPS Payment Update

For FY 2011, the market basket was increased by 2.6 percent to account for inflation. Due to regulations in the Patient Protection and Affordable Care Act (PPACA), the IPPS Final Rule reduced the 2.6 percent update by 0.25 percent. For FY 2011, acute care hospital rates will be increased by 2.35 percent. Hospitals that meet quality data requirements (RHQDAPU) will receive the full 2.35 percent increase. Hospitals that fail to meet quality data requirements (RHQDAPU) will have their update rate reduced by 2.0 percentage points below the market basket, which will result in a 0.35 percent increase.

Documentation and Coding Adjustment

CMS believes that the effects of documentation changes and coding improvements by hospitals in order to receive the fullest payment for care provided (to beneficiaries under the MS-DRGs) have resulted in an increase in payments that does not reflect real changes in the case-mix severity. As a result of this increase, CMS has finalized a -2.9 percent documentation and coding adjustment to recoup payments in FY 2008 and FY 2009 for documentation and coding that do not pertain to actual increases in patient severity. Based upon legislation that was passed in 2007, CMS must "recoup the entire amount of FY 2008 and 2009 excess spending resulting from changes in hospital coding practices no later than FY 2012. CMS has determined that a -5.8 percent adjustment is necessary to recoup all of these overpayments. The -2.9 percent adjustment for FY 2011 is one-half of the necessary adjustment. This reduction, coupled with other adjustments, is estimated to reduce total payments for operating expenses to IPPS hospitals in FY 2011 by 0.4 percent or $440 million."

Interim Final Rule Three-Day Payment Window

The three-day payment rule is often referred to as the 72-hour rule. The rule, however, represents three calendar days. In addition to recently published information from CMS pertaining to the three-day payment window, CMS also provided clarification to this regulation in the IPPS FY 2011 Final Rule. These changes were implemented due to Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Medicare is implementing these changes through an interim final rule with a comment period. The comment period ends on Sept. 28, 2010.

Under this interim rule, hospitals must include diagnostic services and admission related non-diagnostic services provided in hospital outpatient departments within three calendar days (including the day of admission) on the inpatient claim. If a hospital indicates that certain outpatient non-diagnostic services are unrelated to the inpatient admission, separate payment will be made for the unrelated non-diagnostic services under Medicare Part B. The IPPS Final Rule defines an outpatient non-diagnostic service as related "if it is clinically associated with the reason for a patient's inpatient admission."

CMS will create a process for hospitals to indicate when non-diagnostic services are unrelated to the inpatient visit. Additionally, hospitals are required to maintain documentation to support that services are unrelated. CMS plans to utilize a "condition code, modifier, or other indicator" for hospitals to indicate that the outpatient non-diagnostic services are unrelated.

Medicare Cost Report

CMS has created two new standard cost centers for reporting CT scanning and MRI services in hospital cost reports. These will be for cost report periods beginning on or after May 1, 2010 on the new Medicare cost report Form (CMS-2552-10). CMS believes these additional cost centers are necessary to improve the accuracy of estimated costs for these imaging services.

Since there is generally a three-year lag time of when cost report data is available to calculate the relative weights for IPPS and OPPS, the data from these new cost centers will not be available for use in calculating the relative weights for at least three years from the time of submittal. CMS will perform an analysis of the data to determine the impact. The agency will also provide the public with a comment period before cost-to-charge ratios (CCRs) for MRI and CT scans are finalized for use in calculating relative weights.

Partial ICD-9-CM Freeze/ICD-10-CM/ PCS Code Updates:

Implementation of the ICD-10 coding system will occur on Oct. 1, 2013. CMS is considering whether to create a "partial freeze" for the annual updates of the ICD-9-CM and ICD-10-CM/PCS code changes to prevent frequent updates to coding software and instructional materials. CMS considered comments from the ICD-9-CM Coordination and Maintenance Committee meeting as well as written comments published in the IPPS Final Rule. Comments from providers suggested various approaches (e.g. limited freeze, emergency changes only).

CMS agrees that providers, payers and vendors will require time to prepare for the ICD-10 implementation. A decision on whether CMS will incorporate a partial freeze is expected to be announced during the Sept. 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting. CMS has posted an agenda for this meeting at the following link: www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

Hospital Quality Data Reporting (RHQDAPU)

It is the stated goal of CMS to promote quality care to facilitate greater healthcare efficiencies for Medicare beneficiaries. In order to accomplish this goal, CMS adopted widely agreed upon quality measures. CMS generally retains RHQDAPU measures (unless otherwise stated) from the current year. For the FY 2011 payment determination, however, CMS retired one measure, combined two others and added four additional ones. These changes can be reviewed at the link listed below. For more details on these changes and to view all of 45 quality measures for FY 2011 payment determination, please refer to pages 50186-50187 of the IPPS 2011 Final Rule published in the Federal Register.

CMS has also made some changes for payment determination for FY 2012 that can also be reviewed below.

Retired Quality Measure for FY 2011

- Mortality for Selected Surgical Procedures Composite

New Quality Measures for FY 2011

- SCIP-Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 (chart abstracted)
- SCIPInfection-10: Perioperative Temperature Management (chart abstracted)
- Participation in a Systematic Clinical Database Registry for Stroke Care (structural measure)
- Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care (structural measure)

Combined (harmonized) Quality Measure FY 2011

PSI 04 – Death among surgical patients with treatable serious complications and Nursing Sensitive – Failure to rescue was combined into one quality measure below.

- Death among surgical inpatients with serious, treatable complications

New Quality Measures for FY 2012

CMS is adopting eight (see below) of the current 10 Hospital Acquired Conditions (HACs) for RHQDAPU measures for FY 2012 payment determination. These will be claim- based measures. All RHQDAPU Program Quality Measures for FY 2012 payment determination can be viewed on pages 50198-50199 of the IPPS 2011 Final Rule published in the Federal Register.

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing, Injury, Burn, Electric Shock)
- Vascular Catheter-Associated Infection
- Catheter-Associated UTI
- Manifestations of Poor Glycemic Control

Changes to IPPS to Implement the Affordable Care Act:

Due to the passage of the Patient Protection and Affordable Care Act of 2010 on March 23, 2010, CMS has implemented additional changes. We have included several of the changes below; however, to review more details on the changes impacted by the Affordable Care Act, read the IPPS FY 2011 in the Final Rule Federal Register beginning on page 50050.

- Additional Payments for Hospitals With Low per Enrollee Medicare Spending
- Temporary Improvements to the Low Volume Hospital Adjustment
- Protection for Hospitals In Frontier States

For additional details on these topics and other updates as well as changes, please refer to the IPPS Final Rule FY 2011 for your reading enjoyment. ■

About the Author

Jamelyn Bibbins, RN, BSN, MPA, CPC-H, is a Proprietary Coding and Compliance Manager for MedAssets. She has 19 years of combined clinical and financial experience. She has worked as a Registered Nurse, Revenue Analyst, Compliance Auditor, Chargemaster Manager, Revenue Integrity Manager, and Chargemaster and Compliance Consultant.

REFERENCES

IPPS for Acute Care Hospitals and Long Term Care Hospital PPS FY 2011
edocket.access.gpo.gov/2010/pdf/2010-19092.pdf

CMS Fact Sheet: Final Payment and Policy Changes for Inpatient Stays in Acute Care Long Term Care and Certain excluded Hospitals for FY 2011
www.cms.gov/apps/media/fact_sheets.asp

CCFN

TALKING POINTS

By Susan Cinquino, CPC

Medicare Physician Fee Schedule Changes: 2010 Has Been a Rocky Road

TRACKING THE CHANGES TO THE Medicare Physician Fee schedule hasn't been a joy ride for anyone, particularly physicians.

This time last year CMS projected a minus 21.5 percent rate reduction in Medicare Physician Fee Schedule (MPFS) payments. Effective Jan. 1, 2010, the Conversion Factor (CF) was set to decrease from the 2009 CF of $36.066 to $28.406.

So the first quarter of 2010 began with a zero percent update to the Medicare Physician Fee Schedule (MPFS), basically freezing the relative values and payments at 2009 fourth quarter MPFS amounts when The Centers for Medicare & Medicaid Services (CMS) announced a two-month zero percent update that would affect claims with dates of service Jan. 1, 2010 through Feb. 28, 2010. On Mar. 2, 2010, however, the Temporary Extension Act (Pub. L. 111-144) was signed into law and the zero percent update was extended on April 15.

Temporary extensions of the Act (Pub. L.111-157) continued into the second quarter and were now affecting claims April 15 through May 31, 2010. On several occasions, CMS instructed contractors to hold claims for ten-day increments of time to allow Congress to resolve the SGR issue. What's the SGR you might ask?

The Sustainable Growth Rate (SGR) formula, which was included in the Balanced Budget Act of 1997, has been a series of legislative steps Congress has taken since 2003 to call off negative rate impacts. Developed in 2002, the SGR formula was established to aid in determining annual updates for physician services paid under the MPFS. Since then, CMS has diligently taken administrative measures to keep up with congressional legislation. It's been a hard beast to follow.

At the time, CMS stated in a news release, "The Centers for Medicare & Medicaid Services (CMS) believes Congress is working to avert the negative update scheduled to take effect June 1, 2010. To avoid disruption in the delivery of health care services to beneficiaries and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the MPFS, CMS has instructed its contractors to hold claims containing services paid under the MPFS (including anesthesia services) for the first 10 business days of June. This hold will only affect MPFS claims with dates of service June 1, 2010, and later."

End in Sight?

Finally, on May 10, 2010, the hold on claims was removed and the revised fee schedule payment files for physician claims were released to Medicare Contractors. Taken from the CMS Physician Fee Schedule Overview that can be viewed on the CMS website, the agency wrote, "These changes also result in a change to the conversion factor for claims provided from Jan. 1, 2010 through May 31, 2010. The resulting conversion factor applicable to services provided during this time period is $36.0791."

Better news came on June 25, 2010, when CMS announced that with President Obama signing the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act, there would be a positive 2.2 percent increase in the 2010 conversion factor. This new fee schedule was retroactively effective for dates of service on or after June 1, 2010, and for claims of service through Nov. 30, 2010. The CF would now reflect a positive $36.8729 for services furnished during this time period. Regardless of what charges were initially submitted on claims with dates of service on or after June 1, CMS stated that physician practices should not resubmit claims already submitted to their Medicare Contractor for processing. Claims would be automatically reprocessed and providers should consult with their carrier/MAC on specific instructions for their jurisdiction.

MPFS Payment Files No longer Quarterly

As result of the legislative changes that have now taken us into the third quarter of 2010, you will find only two relative value files on the CMS website. Traditionally, the MPFS relative value unit (RVU) files have been based on four quarters within the calendar year (CY). The most current CMS payment files, however, have been transitioned into beginning and end dates to encompass the delays affecting the 2010 release of RVUs.

RVU File PPRRVUC_PCT0 contains the relative value information for date of services effective Jan. 1, 2010, through May 31, 2010. Effective June 1, 2010 through Nov. 30, 2010, RVU File PPRRVUC_PCT22 provides the current values. Both files are available under PFS Relative Value Files on the CMS website at www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage.

Key Notes to 2010 MPFS Final Rule Changes

Development of Practice Expense RVUs
Now based on the American Medical Association's (AMA) Physician Practice Information Survey (PPIS) in place of AMA's Socioeconomic Monitoring Survey (SMS) – Use of the PPIS data and phase-in period over four years from the current practice expense data to the practice expense data developed using the new PPIS data. The phase-in starts with 75 percent of current practice expense data and 25 percent of new data will be used to set the practice expense values for 2010. Then the mix will be 50 percent/50 percent in 2011, 25 percent old data and 75 percent new data for 2012 and 100 percent new data for 2013.

Geographic Practice Cost Indices (GPCIs)
Section 3102 of the Affordable Care Act extends the 1.0 work GPCI floor for services furnished through Dec. 31, 2010.

Malpractice RVUs
CMS will use malpractice premium data for IDTFs instead of medical physicist premium data to determine the malpractice premiums paid by technical component suppliers.

E/M Codes for Consultations are Eliminated
Effective Jan. 1, 2010, consultation codes are eliminated and under the PFS, the use of new and established office visit E/M codes will be reported.

Physician-administered drugs
Removal of drugs from the calculation of the SGR beginning with 2010. Medicare projects this will have a positive effect on future payment updates.

CMS will accept comments on the proposed rule until Aug. 24, 2010, and will respond to them in a final rule to be issued on or about Nov. 1, 2010.

Equipment Utilization Rate
CMS increased the equipment utilization rate assumption used to determine the practice expense for expensive equipment priced over $1 million from 50 to 90 percent and will phase in the change over a four-year period. The change, however, is not applicable to expensive therapeutic equipment.

Imaging Accreditation
The 2008 Medicare Improvements for Patients and Providers Act (MIPAA) requires CMS to establish an accreditation process for those entities that furnish certain advanced diagnostic imaging procedures by Jan. 1, 2012. Requirements will apply to mobile units, physicians' offices and independent diagnostic testing facilities that create the images, but will not apply to the physician who interprets them.

Physician Quality Reporting Initiative (PQRI) and e-Prescribing Program
The final rule simplifies the reporting requirements for the electronic prescribing measure, provides eligible professionals with more reporting options, and establishes a new process for group practices to be considered successful electronic prescribers. CMS added 30 individual PQRI measures and six measures groups on which individual eligible professionals may report and provides an Electronic Health Record reporting option.

What's Coming Next?

The 2011 MPFS Proposed Rule is now on display on the Federal Register website. CMS will issue a final rule on or about Nov. 1, 2010. The proposed rule projects an across-the-board 6.1 percent reduction in fee schedule payments. Unless Congress intervenes, the estimate of the conversion factor based on proposed adjustments made by the Medicare Economic Index (MEI) are to reduce the CF to $26.6574. In addition to the 6.1 percent cut, CMS projects changes that will reflect in a 2 percent decrease for practice expense RVUs.

This proposal is based on estimated changes as a result of the Multiple Procedure Payment Reduction (MPPR) and Medicare Economic Index (MEI). If adopted, the decrease will be implemented during a four-year transition period. CY 2011 is the second year of the four-year transition of practice expense RVUs using the 50/50 blend of the AMA's PPIS data implemented in CY 2010 and previous PE RVUs from the SMS and supplemental survey data.

Summary

As we look at what has been happening this year, it will be increasingly harder to keep track of the changes. Moreover, the ride isn't over yet. ■

About the Author

Susan Cinquino, CPC, is a Quality Review Analyst with the MedAssets. She brings more than 26 years of healthcare experience in various areas that include coding and compliance, revenue cycle management, physician education, consulting services, practice management and healthcare administration for private, professional and facility-based practices.

REFERENCES

CMS National Website:
Physician Fee Schedule Overview
www.cms.gov/PhysicianFeeSched/01_overview.asp

PFS Relative Value Files
www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

May 10, 2010
www1.cms.gov/transmittals/downloads/R700OTN.pdf

MPFS final rule
Go to www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage, and go to CMS- 1413-FC in the first column or www.access.gpo.gov/su_docs/fedreg/a091125c.html

MODIFIERS CORNER

By Sandy Palmer, RHIT

Using Modifiers to Report Reduced or Cancelled Procedures: Part I

THERE ARE FOUR MODIFIERS THAT MAY be appended to the procedure code in circumstances where a procedure has been reduced or discontinued. Using these modifiers allows the facility to report the reduced services performed, which may include charges related to patient prep, supplies used and scheduling of the room.

These modifiers and their descriptions are provided below. Modifier 52 may be used for hospital outpatient, ambulatory service center (ASC) or professional reporting. Modifiers 73 and 74 are applicable to hospital outpatient and ASC reporting only. Modifier 53 is only available for professional reporting of physician services and will not be further discussed in this article.

Modifier 52

Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of Modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see Modifiers 73 and 74

Modifier 73

Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of Modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see Modifier 53.

Modifier 52 may be used for hospital outpatient, ambulatory service center (ASC) or professional reporting. Modifiers 73 and 74 are applicable to hospital outpatient and ASC reporting only. Modifier 53 is only available for professional reporting of physician services and will not be further discussed in this article.

Modifier 74

Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of Modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see Modifier 53.

Modifier 53

Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding Modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/

When multiple procedures are scheduled for a patient during an outpatient visit and not all of the procedures are performed, only the completed procedures are reported. The procedures that were planned and not started would not be reported.

ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see Modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Use of Modifiers 52, 73, 74

When discussing the modifiers used by hospitals to report procedures that were not completed in some form, we need to first discuss the different ways a procedure or service would not be "complete" as the procedure code definition describes it.

The following circumstances would generally be reported with a reduced or cancelled service modifier:

- A procedure that was started, but then reduced, partially reduced, interrupted, discontinued, not performed in its entirety or incomplete
- A procedure that was cancelled, discontinued or terminated due to extenuating circumstances, such as those that threaten the well-being of the patient, according to the physician's discretion
- An inherently bilateral procedure that was performed on only one side of the body
- A procedure with a specified time frame that was performed for less than the listed minimum time

Alternately, the following circumstances would NOT be reported with Modifiers 52, 73 or 74:

- A procedure that was electively cancelled by the patient

Note: Medicare does not pay for procedures when the patient decides to cancel. The intended procedure code and a reduced/cancelled service modifier should not be reported.

- Unsuccessful or failed procedures that were fully performed as intended

A procedure might be considered "unsuccessful" or "failed" although the procedure was completely performed as intended, but the expected or desired outcome was not achieved. HCPCS Coding Clinic provides an example of a completed but unsuccessful procedure in which CPT Code 38221 would be reported for a bone marrow biopsy procedure that was completed, although no marrow was obtained. No modifier would be required since the procedure was fully performed.

- A procedure that was not started when multiple procedures were planned and at least one of the planned procedures was completed

When multiple procedures are scheduled for a patient during an outpatient visit and not all of the procedures are performed, only the completed procedures are reported. The procedures that were planned and not started would not be reported. (If none of the procedures are completed and only one procedure started, then that procedure would be reported according to guidelines with either Modifier 52, 73 or 74.)

- Unsuccessful attempt(s) at a procedure completed on the final attempt

Example: When multiple attempts to perform a lumbar puncture are made before succeeding, only one unit of CPT Code 62270 (Spinal puncture, lumbar, diagnostic) would be reported. No reduced or cancelled procedure modifier would be reported.

Anesthesia

The choice you make as to which modifier to use for a reduced or cancelled procedure may also depend on whether the procedure that was planned required the use of anesthesia. Documentation should also note whether anesthesia had been initiated.

"Anesthesia" for the purpose of these modifier assignments is defined as:

- Local anesthesia
- Regional block(s)
- Moderate sedation/analgesia or conscious sedation
- Deep sedation/analgesia
- General anesthesia

Medical record documentation should also be reviewed for these circumstances:

- At what point was the procedure terminated?

This is important when reporting cancelled procedures and the procedure generally requires anesthesia. If the induction of anesthesia has not begun and the patient is still in a holding room or preoperative suite when the procedure is cancelled or terminated, then that procedure would not be reported. Medicare states that the patient must be taken to the room where the procedure requiring anesthesia is to be performed in order for the facility to report either Modifier 73 or 74.

- Was the procedure initiated?

Documentation in the medical record should state whether the physician actually started the procedure, e.g., "incision made, intubation started, scope inserted, etc."

History of Modifiers, Effect on Payment

Prior to the year 2000, Modifier 52 was used to report all applicable reduced or cancelled procedures in the hospital outpatient setting. After implementation of the facility Modifiers 73 and 74 in 2000 (for procedures requiring anesthesia), Modifier 52 was to be used only for those procedures that did not require anesthesia to be performed. Currently Modifier 52 is most often used with reduced or discontinued imaging procedures and other procedures or services that do not require anesthesia.

Up until Jan. 1, 2006, Modifier 52 was paid at 100 percent of the APC payment. However, in 2004 CMS conducted analyses of hospital claims data and examined usage of Modifier 52. Based on those studies, CMS felt that a reduction in the payment for procedures reported with Modifier 52 was warranted. That reduction went into effect Jan. 1, 2006, and procedures reported with Modifier 52 are currently paid at 50 percent of the APC rate.

Procedures reported with Modifier 73 are also paid at 50 percent of the APC. CMS feels that facilities should have a reduction in expenses for items such as drugs, devices, supplies, equipment, treatment or operating rooms and recovery room time when a procedure is discontinued prior to initiation of the procedure.

However, procedures reported with Modifier 74 are paid the full APC payment amount. CMS feels it is more likely that expenses for procedures appropriately reported with Modifier 74 were "as significant to the hospital provider as for a completed procedure." According to CMS, the 100 percent payment for procedures appended with Modifier 74 may additionally cover resources required to treat and stabilize patients who experience complications.

Summary

It is essential that hospitals have a clear understanding of the use of the modifiers for reduced and cancelled procedures. Correct reporting of these modifiers can help ensure that facilities receive the appropriate compensation for the procedures performed in their facilities.

We will discuss the individual reduced/cancelled services Modifiers 52, 73 and 74 and examples for the use of each in future Modifiers Corner articles.

About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management. ■

REFERENCES

HCPCS Coding Clinic, 3rd Qtr 2007 - Discontinued procedures vs. unsuccessful procedures

Medicare 100-04 Claims Processing Manual | Chapter 4 | Section 20 – Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)
www.cms.gov/manuals/downloads/clm104c04.pdf

Continued from page 8

RACs Move Into Medicaid:Are You Ready?

We hope that by the time the RAC program is expanded to Medicaid, states will have had a chance to read the report published by the Government Accountability Office (GAO) (www.gao.gov/new.items/d10864t.pdf) released on July 15, summarizing all the shortcoming of the Medicare RAC. In its report, GAO found that CMS lacked processes to evaluate RAC findings promptly; to determine appropriate responses to RAC findings; and to implement corrective action promptly. Of note is that CMS has not implemented corrective actions for 60 percent of the most significant RAC-identified vulnerabilities representing $231 million of the roughly $1 billion in improper payments (2005-2010) discovered by the contractors so far.

The Bottom Line

So what does this mean for you? It translates as a heavier administrative burden – more charts, more internal chart dives to make sure that they are accurately coded – and this all translates as more man hours for staff or the extra added burden of hiring more temporary or permanent qualified help.

This of course, translates into increased financial burden to the practice, in an ever-decreasing reimbursement arena in healthcare delivery.

About the Author

Denise M. Nash MD, CCS, CIM, is the Medical Director and Product Owner for MedAssets' Episodes of Care (EOC). Denise has over 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise has also worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of NH for the Fraud and Abuse Division.

CCFN

F.A.Q.

FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Q A patient comes to our outpatient oncology department for a Neupogen injection. Patient had a CBC drawn. Our oncology nursing staff is charging 96372 and 99213 (E&M level) and that brings up a CCI modifier edit. Since the patient came in for a scheduled injection and nothing else was done except for the lab work, is it appropriate to charge the E&M level and add Modifier 59 to the charge?

MedAssets Response

When a patient presents to an outpatient department for a scheduled appointment, as referenced in the scenario provided, only the specific CPT/HCPCS codes should be reported rather than an evaluation and management (E&M) code.

However, if during the scheduled visit the patient condition warrants an evaluation and management service that is above and beyond the scope of the scheduled procedure/or service, it may be appropriate to separately report an E/M level visit based on the facility E/M level assignment guidelines, in addition to the scheduled visit services.

For example, during the scheduled visit the patient complains of chest pain, the physician is notified, an E/M evaluation is provided and the physician orders an EKG. In this scenario, it may be appropriate to report an E/M level with Modifier 59 to indicate a distinct and separate service was provided.

Q For laboratory tests that are on the list of CLIA waived tests for certification, are we required to attach the QW modifier to the code? This is for tests that are done in areas that hold a CLIA certificate.

MedAssets Response

The purpose of Modifier QW is to allow the reporting of waived tests by facilities holding a CLIA Certificate of Waiver. These laboratories must report waived tests codes appended with modifier QW to be paid for these tests.

Facilities with one of the following types of CLIA certification are not required to append modifier QW to waived test codes:

Certificate of Registration (certificate type code 9)
Certificate of Compliance (certificate type code 1)
Certificate of Accreditation (certificate type code 3)

Regulations for the use of modifier QW are found in the Claims Processing Manual Chapter 16, Section 70.

Trade Shows & Events

Baptist Health-Montgomery Educational Meeting

Sept. 15 • Montgomery, AL

Secure Your Revenue With Improved Clinical Documentation

Presented by Sandra Miller, M.D., Senior Medical Director, Revenue Cycle Services, MedAssets

AZ HFMA Fall Conference 2010

Sept. 15-17 • Marana, AZ • Booth TBD
www.azhfma.org

Healthcare Finance News Virtual Conference & Expo

September 15-16
www.himssvirtual.org/hfn/education_sessions.asp

Southern Illinois AAHAM Educational Meeting

Sept. 17 • Bloomington, IL • www.illinoisaaham.com

Unraveling Price Defensibility, Integrity and Transparency for Employees, Physicians and Consumers

The Journey to Cost-Based Defensible Pricing

Presented by Kate Banks, President, Customer Revenue Strategy and Improvement, MedAssets and Joel Lawson, Senior Manager, Pricing Services, MedAssets

20th Annual HFMA Joint Northern/ Southern California Fall Conference

Sept. 19-21 • Long Beach, CA • Booth 21
www.hfma-cafallconf.org

A2HA Educational Meeting

September 20 • Annapolis, MD

Positioning for Health Reform: How Hospitals Will Need To Transform the Delivery of Care

Presented by Stephanie Alexander, President, Performance Analytics, MedAssets

Fall 2010 IDN Summit and Expo

Sept. 21-23 • Phoenix, AZ • Reverse Vendor Fair
www.idnsummit.com

Trends You Should Prepare For Panel Discussion

Presented by Mike Cassady, Senior Vice President, Strategic Alliances and Product Strategy, MedAssets; David McCombs, Vice President, ERP/Supply Chain Operations, Bon Secours Health System, Inc.; Steve Pitzer, System Director, Supply Chain, CHRISTUS; and Moderator: Maria Harnes, Partner, HealthCare Links

HFMA Webcast

Sept. 23 • 2:00 p.m. CST • www.hfma.org/webinars

Increasing Cash Flow With Expected Reimbursement For All Payors

Presented by Valerie Woodbury, BBA, CHFP, AVP, Revenue Integrity, Ardent Health Services and Troy D. Roth, Vice President, Revenue Cycle Strategy, MedAssets

57th Annual MI HFMA Fall Conference

Sept. 30-Oct. 1 • Plymouth, MI • Booth TBD

The McLaren Health Story: Achieving Operational Improvements by Streamlining and Standardizing Tools, Systems and Processes

Presented by Julia Langdon, Director, Finance and Reimbursement, McLaren Regional Medical Center and Julie Waddell, Vice President, Revenue Cycle Solutions Strategy, MedAssets

CAHAM 43rd Annual Educational Conference and Exhibition

October 3-6 • Las Vegas, NV • Booth TBD
www.caham.org/calendar.php

MAHAP/MPAA Revenue Cycle Conference

Oct. 6-8 • Mt. Pleasant, MI
www.mahap.org/programs2009-2010

Creating a Vision: The Complexities of the Patient Financial Clearance/ Securitization Process

Presented by Julie Waddell, Vice President, Revenue Cycle Solutions Strategy, MedAssets

California Association of Healthcare Purchasing and Materials Managers (CAHPMM) Annual Conference

Oct. 12-14 • Shell Beach, CA • Booth TBD
www.cahpmm.org

The Effects of Healthcare Reform on Supply Chain Management

Presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

AAHAM ANI

Oct. 13-15 • Ft. Lauderdale, FL • Booth 303
www.aaham.org/AnnualNationalInstitute

Integrity Contractor Basics

Presented by William Davis, Vice President, Consulting Services, Revenue Cycle Technology, MedAssets

Georgia Access Management Association (GAMA) Fall 2010 Annual Meeting

Oct. 13-15 • Helen, GA

Lean Management: Increase Efficiency and Improve Quality in Healthcare

Presented by Kenneth Thomson, Senior Vice President, Client Engagement, MedAssets and John Lees, PhD, President, Revenue Cycle Services, MedAssets

HFMA 2010 Fall Seminar Series

Oct. 19-21 • Denver, CO

Using Metrics to Reduce Service Line Supply Cost

Presented by Dan Piro, President; Erik Axter, Vice President; Lisa Dietz, Vice President; and Blane Schilling, M.D., Vice President, Clinical Pharmacy Services, Aspen Healthcare Metrics, a MedAssets company

New Jersey HFMA Annual Institute

Oct. 20-22 • Atlantic City, NJ
www.hfmanj.org/Events.calendar

Lean Management: Increase Efficiency and Improve Quality in Healthcare

Presented by John Lees, PhD, President, Revenue Cycle Services, MedAssets

7th Annual AHVAP (Association of Healthcare Value Analysis Professionals) Continuing Education & National Conference

Oct. 20-22 • Myrtle Beach, SC • Booth TBD
ahvap.org/annualconference.asp

Expediting Value Analysis Through Data Transparency

Presented by Gina Thomas, RN, BSN, MBA, CMRP, Vice President, Customer Management, MedAssets

CCFN CROSSWORD **AUGUST 2010**

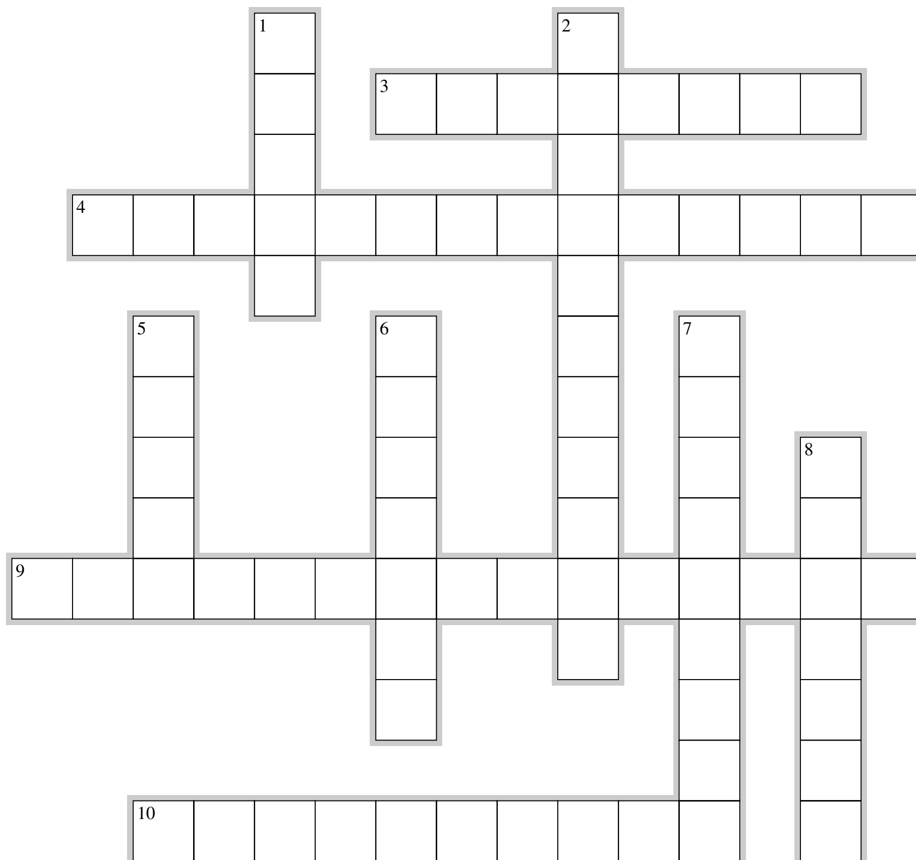
By Nikita Ashford, MBA/HCM, CPC-H, CPhT

Across

3. ICD-10 will use two types of these notes.
4. If the provider has documentation for a diagnosis, but no specific diagnosis exists, then this diagnosis applies. (2 words)
9. These guidelines when listed in ICD-10 will take precedence over the general guidelines provided. (2 words)
10. In ICD-10, the diagnosis area will now include both general and chapter-specific ____.

Down

1. The ICD-10 diagnosis codes, has the possibility of expanding to ____ digits.
2. If an ICD-10 code requires a seventh digit, but only has five, the letter "X" will be used as a ____.
5. The ICD-10 diagnosis codes first digit will consist of this type of digit.
6. The digits following the ICD-10 diagnosis code's first digit may be an alpha or ____ digit.
7. One change relating to ICD-10, the diagnosis coding system will be used by all ____.
8. Common seventh digits for ICD-10 include A for the ____ encounter, D for subsequent encounter, and S for sequela (late effects).



ANSWERS
ACROSS 3. EXCLUDES 4. OTHER SPECIFIED 9. CHAPTER-SPECIFIC 10. GUIDELINES
DOWN 1. SEVEN 2. PLACEHOLDER 5. ALPHA 6. NUMERIC 7. PROVIDERS 8. INITIAL

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