Philadelphia Medicine

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ICD-10: Frequently Asked Questions

Many physicians and practice managers are concerned about preparing for the October 2013 transition to ICD-10 when the number of codes drastically increases from about 14,000 to 170,000. While the implementation date to upgrade to version 5010 was January. 1, 2012, the CMS announced that it will delay enforcement until April 1, 2012, to give providers more time to comply.

As many providers have not yet certified their version 5010 software, DPW is temporarily waiving the certification requirements for existing electronic submitters through March 31, 2012. However, if your software has not been certified, DPW cannot guarantee that PROMISe™ will be able to accept the claims, which may delay reimbursement. Therefore, DPW strongly recommends that providers certify their software before submitting electronic claims.

Beginning April 1, 2012, all existing electronic submitters who have not successfully submitted a claim to PROMISe™ will have to go through the certification process or their electronic files will be rejected. New submitters to PROMISe™ will have to certify their software beginning Jan. 1, 2012.

- What is ICD-10?
  ICD-10 stands for the International Classification of Diseases, 10th Edition, and is a diagnostic coding system implemented by the World Health Organization (WHO) in 1993 to replace ICD-9. ICD-10 is used in almost every county in the world except the United States.
- When is the ICD-10 compliance date?
  Oct. 1, 2013
- Will the ICD-10 compliance date be postponed?
  There are no plans to extend the Oct. 1, 2013 compliance date.
- Will ICD-10 replace CPT procedure coding?
  No, this change will not affect CPT coding for providers.
- Why is ICD-9 being replaced?
  ICD-9 has become outdated and cannot accurately describe diagnoses with the level of detail needed for the reporting purposes of our healthcare system.
- When will ICD-9 codes stop being accepted?
  ICD-9 codes will not be accepted for dates of service on or after Oct. 1, 2013. ICD-10 codes on the other hand, will not be accepted for services prior to Oct. 1, 2013.
- Every year we experience diagnosis code changes, so why is the transition to ICD-10 different from the annual code changes?
  ICD-10 has a completely different structure than ICD-9. Some of the key differences are that ICD-10 is alphanumeric and contains three to seven characters. ICD-10 is also more robust and specific, allowing for coding of laterality, stages of pregnancy, etc.
- Will there be a grace period for ICD-9 once ICD-10 is implemented?
  No, there is no indication that providers will be granted a grace period.
- Will overly detailed medical record documentation be required for ICD-10?
  As with ICD-9, ICD-10 codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity.
- What are the benefits of ICD-10?

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PCMS NEWS

PCMS Upcoming Events

Programs are held at PCMS headquarters unless otherwise noted. You must register to attend each program: 215-563-5343, Ext. 113. There is no fee to attend.

Practice Managers
"Contracting Pitfalls," and ICD 10 Update
Wednesday, March 7, 2012, 11:30 AM - 1:30 PM
Luncheon meeting

Residents and Fellows
"Understanding Your Employment Contract: A Legal Review"
Speaker: Daniel Shay, Esquire
Thursday, March 8, 6:00 - 8:00 PM

Young Physicians
Meet and greet PAMED President, Marilyn Heine, MD, followed by section organization meeting
Thursday, March 15, 6:00-8:00 PM

All PCMS Members
"CME COPD Program"
Speaker: Frank Leone, MD, MS, Director, Comprehensive Smoking Treatment Program, University of Pennsylvania
Tuesday, March 20, 6:00 - 8:00 PM

All events are posted on the PCMS website. These include CME programs and seminars from outside sources.
If you would like to post your event on the website, call 215-563-5343, Ext. 102

SAVE THE DATE!
Saturday, June 9, 2012
PCMS President's Installation and Awards Night
Celebrating the Inauguration of
Harvey B. Lefton, MD
151st President
The Philadelphia County Medical Society
To be held at The Rittenhouse Hotel
210 West Rittenhouse Square
Philadelphia, PA

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HMI HEALTHCARE MEDIA INTERNATIONAL

Editorial

Media and the doctor-patient relationship

By Lynn M. Lucas-Fehm, MD, JD

Once upon a time there existed the much revered fictional TV doctor who exhibited compassion, wisdom and the ability to cure virtually any disease in neat 60-minute episodes. Marcus Welby MD was the prime example of this early portrayal of the benevolent father figure who could succinctly advise and heal the body and soul.

As television became increasingly in love with the genre known as the situation comedy, the revered doctor became an everyman, possessing the ability to heal while also making us laugh and cry about the realities of illness, trauma and death. Hawkeye and Trapper John of M.A.S.H. supplied many viewers with hours of laughter while making us contemplate the horrors of war.

Today's medical shows have become a mix of soap opera, drama, and character studies with shows like Grey's Anatomy and House MD.

Through the years these varied medical shows have been a staple in the American households' television/cable viewing schedule.

However, one thing has changed: in the past only fictional doctors were prevalent on television while real physicians rarely involved themselves in such a public enterprise. In contrast, while today's fictional doctors continue to be characters in comedies, detective shows, and soap operas, real doctors have emerged as medical reporters, talk-show hosts and even infomercial participants.

The question to consider is whether this media involvement by real physicians is good for patients and the medical profession. Can sound medical advice be delivered in a sound bite or internet blog? Many of us field questions on a daily basis about information gathered from a google search or obtained from one of our medical colleagues on TV. There is no simple answer, but in the final analysis we are at a point of no return. The medical media industry is here to stay and we each have to find a way to stay informed about what our patients are watching and reading so that we are ready to advise, consult and sometimes correct the information gleaned from a two-minute medical synopsis viewed on a talk show.

The public's growing fascination and reliance on media for medical expertise has also resulted in the birth of doctor rating internet sites where patients post information about and rate their experiences with medical professionals. These ratings have become a source of frustration for many physicians who have found their reputations called into question by a less than complementary website rating. Patients grade doctors, commenting on everything from their knowledge base to interpersonal skills and timeliness.

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Proponents of such sites point out that patients are customers who are paying for a service and should be able to openly express their level of satisfaction. They argue that informed consumers will make better choices about how to spend healthcare dollars.

Critics see the sites as defamatory and one-sided. If a doctor gets his bedside manner slammed with a negative review that he/she feels is unfair, federal privacy law prevents him/her from discussing the particulars of the case in a rebuttal.

My concern about such rating systems is not so much what they are trying to do but the way they are going about it.

Many sites boast of thousands of ratings but often only two or three patient reviews may have been placed about any single physician. The average physician sees hundreds of patients in a year. Should these few ratings—good or bad—be taken as representative of

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Media and the doctor, *from page 2*

the doctor's ability? With so few ratings per doctor, validity of the ratings is an issue. What if someone with a grudge is responsible for all of the negative comments or someone with a vested/monetary interest is writing multiple rave reviews? The site owners have no way of knowing if this is happening.

Not only is validity an issue but the impact of these ratings on the doctor-patient relationship must also be considered. In reaction to negative comments, some doctors have invested money in managing their images by running their own websites, increasing advertising budgets and hiring companies that provide contracts to new patients requiring them to ask their doctor's permission before grading him or her online.

Somewhere in the midst of this media/internet driven scenario there must be room for compromise. Patients need to have their say about what doctors are doing right and what can be improved. However, their opinions need to be collected in an accurate and meaningful way that takes into account the complexity of healthcare delivery.

Unfortunately, there is no Relative Value Unit [RVU] for the nurturing of the doctor-patient alliance, but it is a vital part of patient care. If we do not find a way to address and evaluate our success in cultivating this relationship, someone else will do it for us.

*Dr. **Lucas-Fehm** is president of PCMS.*

Hospital hiring of physicians picks up steam

Hospitals increased their physician hiring in 2011, and hospital employment of doctors shows no signs of slowing in 2012, with doctor hiring becoming a major strategy for hospitals getting ready for health system reform.

Meanwhile, physicians already on staff may find hospitals providing financial and other incentives to keep them on board.

Physician hiring at hospitals has shot up in recent years. Although an American Hospital Assn. survey includes dentists in the hiring category, few are employed by the community hospitals surveyed.

ICD-10: Frequently Asked Questions, *from page 1*

There are a number of benefits such as: improving accuracy of claims processing; higher quality data for measuring healthcare service quality, safety and efficiency; better tracking of patient outcomes; and possible increase in reimbursement.

- How many diagnosis codes are there in ICD-10 compared to ICD-9?
  ICD-10 has approximately 69,000 codes compared to the 15,000 codes in ICD-9.
- What should providers be doing to prepare for the transition to ICD-10?
  Providers can begin to prepare by talking with their billing service, clearinghouse, and practice management software vendors. Identify needs and resources, such as training. Start with the Pennsylvania Medical Society's webinar on ICD-10. An ICD-10 transition plan should take into account specific practice or organization needs, vendor readiness, staff knowledge and training.
- When should I begin training on the new ICD-10 code set?
  To ensure ICD-10 coding education is retained through the Oct. 1, 2013 implementation date, it is recommended that practices wait until at least late 2012 to begin comprehensive ICD-10 coding training.
- Are there any guidelines to assist with the mapping between ICD-9 and ICD-10?
  Yes. The 2011 General Equivalence Mapping (GEM) documents are available on the Centers for Medicare and Medicaid Services' website. The GEMs are forward and backward mappings, also called crosswalks, between the ICD-9 and ICD-10 coding systems.
- Where can I find the ICD-10 code sets?
  The ICD-10 code sets are available free of charge and can be found on the following websites:
  CMS: www.cms.gov/ICD10/12_2010_ICD_10_CM.asp
  WHO: www.who.int/classifications/icd/en/
  CDC: www.cdc.gov/nchs/icd/icd10cm.htm#10update
- If I don't participate with Medicare, will I have to transition to ICD-10?
  Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must transition to ICD-10 on Oct. 1, 2013, including providers and payers who do not participate with Medicare.

NEW: "Opt-Out" testing part of PA standard of cCare

As a result of a recent change to Pennsylvania law, HIV testing is now recommended as part of the routine standard of care for patients aged 13 to 64. Patient consent has been revised to permit an "opt-out" process where patients are told an HIV test will be performed as part of their routine lab work unless the patient specifically declines. These changes bring Pennsylvania law into line with the 2006 CDC HIV testing guidelines.

Routine HIV testing promotes earlier detection of HIV infection; helps prevent transmission of HIV; provides an opportunity to identify and counsel people with unrecognized HIV infection and link them to clinical services.

All HIV screening must continue to be voluntary, undertaken only with the patient's knowledge.

Patients should be provided an opportunity to ask questions before getting tested.

Pennsylvania's revised law now provides an important tool in our fight to provide earlier clinical care for people with HIV infection and reduce the spread of HIV.

To request patient and provider materials, HIV clinical care referral options, and technical assistance, please email hivtest@healthfederation.org.

Host your event at PCMS

Host your next party or conference/seminar at PCMS headquarters. Ample free parking. Contact Louise Eder on 215-563-5343, Ext. 107 to schedule an appointment.

pcms people

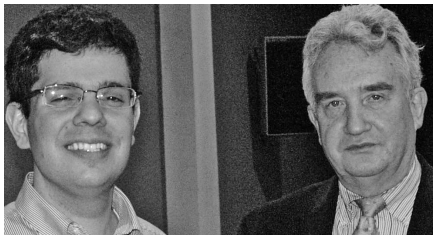
Kenneth E. Wasserman, MD, has received The Pennsylvania Academy of Dermatology and Dermatologic Surgery's "Dermatologist of the Year Award" presented at the Academy's 44th Annual Meeting. Dr. Wasserman serves as a team physician for the Baltimore Orioles baseball team. He is also the founder of Play Smart in the Sun, a major league baseball skin cancer program.

Lawrence J. Solin, MD, FACR, FASTRO, Chair of the Department of Radiation Oncology at Albert Einstein Medical Center, presented study results at the 2011 San Antonio Breast Cancer Symposium. The study detailed that researchers have developed and prospectively validated a multigene test to identify the risk for recurrence of ductal carcinoma in situ (DCIS) of the breast.

Peter LeRoux, MD, FACS, associate professor of neurosugery in the Perelman School of Medicine at the University of Pennsylvania, has been awarded a three- year, $250,000 Dana Foundation Clinical Neuroscience grant to conduct a study using branch chain amino acids to treat concussion in athletes.

Mark C. Austerberry, PCMS Executive Director, has been appointed a reviewer to serve on an evaluation panel for the Centers for Medicare & Medicaid Health Care Innovation Challenge, a new initiative designed to test a wide range of innovations in communities across the country in order to accelerate systemwide healthcare transformation.

Richard Baron, MD, Seamless Care Models Group Director, CMS, discussed the impact that the new rules in the Healthcare Reform Act of 2011 will have on the forming ACOs at a recent PCMS Board of Directors meeting.



From left: Kurt Miceli, MD, the new chairman of the PCMS Young Physicians Section; and Ricardo Morgenstern, MD, the new chairman of the PCMS IMG Section. Both Drs. Miceli and Morgenstern serve on the PCMS Board of Directors.

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