CMS Preventive Exam CPT Changes for 2011

G0402 Initial Preventive Physical Examination
Welcome to Medicare Physical must be billed prior to G0438 or G0438 will be denied. MUST wait 366 days to do G0438

G0438 Annual Wellness Visit
Bill 366 days after G0402 and if performed/billed to soon will get denial reading ‘Benefit maximum for this time period or occurrence has been reached.’ This pays roughly the equivalent of a 99204 as CMS crosswalked this RVU assignment to this code.

G0439 Subsequent Wellness Visit
This service must come subsequent to the prior two wellness codes and it pays roughly equivalent to a 99214 due to an analogous crosswalk. If either G0438 or G0439 are submitted during initial 12 months of Medicare eligibility then services will be denies as ‘expenses incurred prior to coverage’ since the G0402 is the appropriate code to be used for this service in this time period.

There is no fee to beneficiaries (no copays or deductibles applied) as this is a fully covered service, but Rural Health Clinics will likely have to wait 30 days to receive payment and can anticipate some SNAFUs to ensure beneficiaries are not subsequently charged a copayment or deductible. Other preventive services that strict indemnity beneficiaries would typically be required to pay or Medicare Advantage would impose a copay and/or deductible are now covered. Furthermore, these services should be charged in addition to the above G codes WITHOUT a 25 modifier that is typically required for services provided with annual preventive examination CPT code that are not part of that annual preventive exam (i.e.: skin lesion identified needing biopsy or a blood pressure medication that is adjusted, both necessitating an appropriate, separate E&M code with the preventive service(s).)

Screening services now covered (Jan 1, 2011) without a copay are:
- G0402
- G0436 and G0437 Smoking and Tobacco Cessation Counseling
- G0101 Screening Pelvic/Breast Examination
- Q0091 Screening Pap Smear Collection
- 97802-97804, G0270-G0271 Medical Nutrition Therapy Services
- 77052, 77057, G0202 Screening Mammography
- G0130, 77078-77083, 76977 Bone Mass Measurement
- G0104, G0105, G0121, G0328 Colon Cancer Screening

Service may be provided by an eligible provider (MD, DO, NP, PA) or medical

1 Medicare Learning Network Number MM7079 Revised; Dec 3, 2010.
2 Section 4103 of the Affordable Care Act 2010
professional (including a health educator, registered dietitian, nutrition professional, or other license practitioner or a team or medical professionals working under direct supervision (not defined) who accepts Medicare Assignment.

**G0402 Documentation must include:**

1. Past Family, Medical and Social History
2. Establishment of a list of providers who regularly provide care to this patient.
3. BMI and Vital Signs and other medically relevant measurements
4. Cognitive Evaluation
5. Risk factor review for depression with appropriate screening tools
6. Functional ability and safety level analysis
7. Establishment of a written screening plan for the next 10 years
8. Establishment of Risk Factors for which primary, secondary and tertiary interventions are recommended or underway including mental health or any such risk factors or conditions identified in examination visit
9. Furnishing personalized health advice and, where appropriate, in addition to diagnostics and screening, provide education and/or counseling intervention.
10. Voluntary advance care planning. Implied this can be refused.
11. “Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NC) process.”

**G0438 and G0439 Documentation include all of the above, but with updates.**

**ICD-9 CM Changes for 2011**

488: Influenza due to certain influenza viruses
   488.0 Due to Avian flu
   488.01 Due to Avian flu w/ pneumonia
   488.02 Due to Avian flu w/ other respiratory signs and symptoms
   488.09 Due to Avian flu w/ other manifestations

488: Influenza due to certain influenza viruses
   488.1 Due to H1N1
   488.11 Due to H1N1 w/ pneumonia
   488.12 Due to H1N1 w/ other respiratory signs and symptoms
   488.19 Due to H1N1 w/ other manifestations

Foreign body retained (old) (nonmagnetic) (in) V90.9
   anterior chamber (eye) 360.61
   magnetic 360.51
   ciliary body 360.62

---

3 ICD-9 CM 2011

Douglas J. Jorgensen, DO, CPC, FACOFP
AAO Convocation Handout 2011
www.patient360.com
magnetic 360.52
eyelid 374.86
fragment(s)
  acrylcs V90.2
  animal quills V90.31
  animal spines V90.31
  cement V90.83
  concrete V90.83
  crystalline V90.83
depleted
  isotope V90.09
  uranium V90.01
  diethylhexylphthalates V90.2
  glass V90.81
  isocyanate V90.2
  metal V90.10
  magnetic V90.11
  nonmagnetic V90.12
  organic NEC V90.39
  plastic V90.2
  radioactive
  nontherapeutic V90.09
  specified NEC V90.09
  stone V90.83
  tooth V90.32
  wood V90.33

globe 360.60
  magnetic 360.50
  intraocular 360.60
  magnetic 360.50
  specified site NEC 360.69
  magnetic 360.59
  iris 360.62
  magnetic 360.52
  lens 360.63
  magnetic 360.53
  muscle 729.6
  orbit 376.6
  posterior wall of globe 360.65
  magnetic 360.55
  retina 360.65
magnetic 360.55
retrobulbar 376.6
skin 729.6
    with granuloma 709.4
soft tissue 729.6
    with granuloma 709.4
specified NEC V90.89
subcutaneous tissue 729.6
    with granuloma 709.4
vitreous 360.64
    magnetic 360.54

787.6 Fecal Incontinence Removed
787.60 Full Fecal Incontinence
787.61 Incomplete Evacuation
787.62 Fecal Smearing
787.63 Fecal Urgency

V13.23 PMH Vaginal Dysplasia
V23.24 PMH Vulvar Dysplasia

V49.86 DNR Status
V49.87 Physical Restraint Status

485.41 BMI 40.0-44.9
485.42 BMI 45.0-49.9
485.43 BMI 50-59.9
485.44 BMI 60-69.9
485.45 BMI ≥ 70
Disclaimer

This seminar provides guidelines, recommendations and interpretations that are to be used as a guide for implementation in your practice(s). The actual implementation and interpretation of these guidelines/recommendations and/or coding/documentation performed is done at the sole discretion of the provider(s) and his/her staff. As such, the provider(s) and his/her staff accept sole responsibility for these decisions and the potential repercussions. Jorgensen Consulting, LLC, Patient360 and/or its parent companies and/or the AAO do not accept any liability in this regard.
It’s never the money...

But it’s always the money!
Agenda

• On change...
• Happenings around the US & what are you doing to adjust—or are you?
• CPT Update for 2011
• ICD-9 Updates and ICD-10 changes
• Recovery Audit Contractors (RAC Audits)
• Trying to survive or simply trying to get by?
• A realistic outlook on available revenue opportunities and payment reform
The 6 Steps of Change

1. Recognize the need for change.
   Contemplative
2. Diagnose the problem.
   Determination
3. Identify alternative methods and strategies.
   Action
4. Prioritize and select
   Maintenance
5. We must implement the change.
   Terminate
6. We must measure and evaluate (re-evaluate) the change.
On Change...

Stubbornness is a virtue…

it’s only a character flaw when you’re wrong!

Charles Henry Noll
Pittsburgh Steelers
Head Coach 1969-1991
4 Super Bowls and Hall of Famer
The Facts

• 30% Reduction in Primary Care by 2011\textsuperscript{1}
• 34% Practices Losing Money\textsuperscript{1}
  • Despite 20+ patients/day
  • 76.29% Practices ‘full capacity’ or overextended’ and ‘overworked’
• $\sim700$ Billion in Waste in US Healthcare System\textsuperscript{2}
• 40% Unnecessary Care: $250-$325M/annum
  • Acts of Commission: Antibiotics, imaging, etc.
  • Defensive Medicine
• 19% “Fraud” $125$ to $175$ Billion/annum\textsuperscript{2}
• 50% Say they ‘won’t change’ despite these facts

\textsuperscript{1}The Physicians’ Foundation Report 2008
\textsuperscript{2}Waste in the U.S. Healthcare System Pegged at $700$ Billion Thomson Reuters 10/26/09
On Change…

All is in flux…

the only constant is change.

Heraclitus
Greek Philosopher
500 B.C.
2011 ICD-9 CM Changes

Avian Flu

488: Influenza due to certain influenza viruses
   488.0 Due to Avian flu
   488.01 Due to Avian flu w/ pneumonia
   488.02 Due to Avian flu w/ other resp. s/s
   488.09 Due to Avian flu w/ other manifestations
2011 ICD-9 CM Changes

H1N1

488: Influenza due to certain influenza viruses
   488.1 Due to H1N1
   488.11 Due to H1N1 w/ pneumonia
   488.12 Due to H1N1 w/ other resp. s/s
   488.19 Due to H1N1 w/ other manifestations
2011 ICD-9 CM Changes

Department of Defense Initiative

Foreign Bodies

780.33 Postraumatic Seizure
  Medical necessity for ongoing monitoring of TBI

784.92 Jaw Pain (mandible/maxilla)
  May help with TMJ Syndrome patients
2011 ICD-9 CM Changes
The Poop...

787.6 Fecal Incontinence Removed
787.60 Full Fecal Incontinence
787.61 Incomplete Evacuation
787.62 Fecal Smearing
787.63 Fecal Urgency
2011 ICD-9 CM Changes

V Codes

V13.23  PMH Vaginal Dysplasia
V23.24  PMH Vulvar Dysplasia
V49.86  DNR Status
V49.87  Physical Restraint Status
2011 ICD-9 CM Changes

BMI!

485.4 For BMI >40 no longer used
485.41 BMI 40.0-44.9
485.42 BMI 45.0-49.9
485.43 BMI 50-59.9
485.44 BMI 60-69.9
485.45 BMI ≥ 70
2011 CPT Changes for CMS Annual Wellness Visits

G0402 Initial Preventive Physical Examination Welcome to Medicare Physical Billed First
G0438 Annual Wellness Visit
G0439 Subsequent Wellness Visit
Covered service for providers accepting Medicare Assignment
Must be 12 months apart to the day
Provider Shortfall

- American Academy of Family Practice: - 40,000 doctor shortage by 2020
- Primary Care Lowest Paid Doctors in USA - Northeast lowest for all doctors nationally
- Medicare and Private Payers not keeping up with cost of living or inflation
- Primary Care not the only specialty affected
Contemporary Provider Data

- >500,000 Practicing Physicians in the US
- >250,000 Specialize in Primary Care
- ~20,000 Physician Assistants in Primary Care
- ~90,000 Nurse Practitioners in Primary Care

US Department of Labor 2008
http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3353
https://catalog.ama-assn.org/MEDIA/ProductCatalog/m270018_PCD_04_table_1.9.pdf
Vanishing Reimbursement

- Transthoracic Echo w/ Spectral & Color Doppler
  - 42% Cut
- SPECT/Myocardial Perfusion Imaging (78452)
  - 36% Cut
- Left Heart Catheterization (93510-26)
  - 24% Cut
- EKG (93000)
  - 21% Cut
- Coronary Stenting (92980)
  - 4% Cut
- Cut Level 4 established patient office visit (99214)
  - 11% Increase (RAC)
HIT Issues

- 40-80% of Medical Practices have no HIT
- <4% Fully Integrated EMR/Practice Mgmt
- Under HIPAA Electronic Billing Required
  - Typically manual entry
- Reporting and Interface Capabilities
- Cost is the major impediment to HIT implementation in small/HPSA practices

CDC & POMIS Report 2008
http://www.cdc.gov/nchs/data/nhsr/nhsr023.pdf
Robert Wood Johnson Foundation  HIT in US, Where We Stand 2008

NOTES: Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2009 data are preliminary estimates (as shown on dashed lines), based only on the mail survey. Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Fully functional systems are a subset of basic systems. Starting in 2007, the skip pattern after the all or partial EMR/EHR systems question was removed. Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists.

SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.
Pose a question?

Is there enough money to get into the HIT world to improve your and your patients quality of life and ease into reporting metrics? (and score well on them!)

Yes!

(But it might not be where you think it is!)
Federal Funding

- 1st Quarter 1996 $12.4B 1Q 38M Beneficiaries
  - >$326/beneficiary/quarter
- 4th Quarter 2009 $23.7B 44.1M Beneficiaries
  - >$537/beneficiary/quarter
- 4th Quarter 2010 $20.9B 46.6M Beneficiaries
  - >$448/beneficiary/quarter

The Numbers...

• Where is the money going?
What did we do in response?

• Procedural workshops
• Aesthetic Medicine
• Volume
• Tupperware?
No increase

JOINT INJECTION  28.4% REDUCTION

2001  2002  2003  2004  2005  2006  2007  2008

DSA 2008
No increase

CERUMEN REMOVAL = 28.1% REDUCTION
Not everything went down

**ABI - 78.0% Increase**

<table>
<thead>
<tr>
<th>200</th>
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<tr>
<td>93922</td>
<td>57.2</td>
<td>56.5</td>
<td>49.8</td>
<td>73</td>
<td>76.4</td>
<td>101</td>
<td>100</td>
<td>102</td>
<td>106</td>
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</table>

DSA 2008
Another Increase

ANSAR = 13.9% INCREASE

$134.00
$139.00
$144.00
$149.00
$154.00

A Raise from CMS (congress)!

Medicare Allowed Expenditures ($ billions)
= 40.8% Increase

<table>
<thead>
<tr>
<th>Year</th>
<th>Billions</th>
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<tr>
<td>2000</td>
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<td>2001</td>
<td>$14.9</td>
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<tr>
<td>2002</td>
<td>$16.1</td>
</tr>
<tr>
<td>2003</td>
<td>$17.3</td>
</tr>
<tr>
<td>2004</td>
<td>$18.4</td>
</tr>
<tr>
<td>2005</td>
<td>$19.2</td>
</tr>
<tr>
<td>2006</td>
<td>$19.6</td>
</tr>
<tr>
<td>2007</td>
<td>$20.0</td>
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</tbody>
</table>

DSA 2008
A Raise Indeed!

Medicare Allowed Expenditures ($ billions)

= 66.9% Increase

<table>
<thead>
<tr>
<th>Year</th>
<th>Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$14.2</td>
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<td>2002</td>
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<tr>
<td>2004</td>
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<td>2005</td>
<td>$19.2</td>
</tr>
<tr>
<td>2006</td>
<td>$19.6</td>
</tr>
<tr>
<td>2007</td>
<td>$20.0</td>
</tr>
</tbody>
</table>

$20.6B (4Q 2010)
Necessity is the Mother of Invention…

- How Most PCPs practice
- The Role of Capital Equipment (Shift in Money)
  - Add an appropriate service
  - Medically Necessary (ICD supports CPT)
  - Increase Income Appropriately with EBM
- Preventive Medicine is Key (37th World Ranking)
- Better Patient Outcomes and Greater Income
- Identify Symptomatic and Asymptomatic Patients
- Parity in some specialty practices too
Practical Implementation

• How is this done?

• Perform a Critical Analysis of Your Existing Practice.
# Chronic Disease Epidemiology Data

<table>
<thead>
<tr>
<th>Disease</th>
<th>Prevalence</th>
<th>Incidence 60,000 pt</th>
<th>Incidence 3,000 pt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>25.5%</td>
<td>15,300 patients</td>
<td>765 patients</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7.4%</td>
<td>4,400 patients</td>
<td>220 patients</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>8.1%</td>
<td>4,860 patients</td>
<td>243 patients</td>
</tr>
<tr>
<td>Hyperlipidemia (Cholesterol)</td>
<td>17%</td>
<td>10,200 patients</td>
<td>51 patients</td>
</tr>
<tr>
<td>Anticoagulation Disorders</td>
<td>2.3%</td>
<td>1,380 patients</td>
<td>69 patients</td>
</tr>
<tr>
<td>Asthma</td>
<td>9.9%</td>
<td>5,940 patients</td>
<td>297 patients</td>
</tr>
</tbody>
</table>
The Goal

Profitability
- Reduce costs
- Increase revenue

Ideal Medical Practice
- Reduce overhead
- Faster throughput
- Comprehensive support for claims and legal issues

Risk Management
- Improve billing
- Accurate and organized records and billing
- Reduce compliance risks and legal action

Efficiency
- Improve staff and office efficiency
On Accepting Change...

Accept that some days you are the pigeon and some days you're the statue.

Author Unknown
Medical Record Audit Data
Anytown USA

- Codes Match: 70%
- Under Coded: 19%
- Over Coded: 11%
- No Code Possible: 0%

Legend:
- Codes Match
- Under Coded
- Over Coded
- No Code Possible
Federal Focus

- HIPAA
- STARK I & II
- Fraud and Abuse
  - Federal (> $40 Billion)
  - RAC Audits are here
  - Commercial/Private
  - 1997 vs. 1995 Documentation Guidelines
- EMTALA
Physician Regulatory Insurance Program

• Boynton & Boynton’s
• Defense and Indemnity Coverage
• Underwritten: Lloyds of London
• 6 years retroactive
• Affordable up to $1,000,000 in coverage for solo doctor practice
• Simple Application

www.complyffacts.com (888) 426-9686
What to do if I’m Audited

• First: What type of audit is it?
  – Prospective Payment
  – Penal Audit
  – Patient Complaint
  – Select Code Review
  – Recovery Audit Contractors (RAC)
What not to do if I’m audited

• Shove the letter into a drawer
• Throw it away hoping it will go away
• Send them everything they asked for
• Invite them to come see what you are doing and they will see what a good job you’re doing
• Do your own audit to prove they’re wrong
• Yell at the auditor and be confrontational
When do I call an attorney?

• If there is a hint of penalty
• If the letter suggests repayment of money.
• If there is a hint of expansion of scope.
• If you are uncomfortable with the line of questioning or innuendo in the letter.
Why involve a lawyer?

- One single reason: Attorney-Client Privilege
- Audits to defend you are done via legal counsel
- Audits done outside counsel are completely discoverable by the investigator (self/hired)
- An attorney is there to protect your best interests
Why audits occur?

- RAC audits: the money is already spent
- Statistical outliers (defensible or not?)
- Tip (patient or code combination)
- Pushing the envelope (not necessarily a bad thing)
Health Care Financing Administration (HCFA*)

Common Procedural Coding System (HCPCS)

Diagnosis Codes → ICD-9
(Creates Medical Necessity)

Level I → CPT
Updated annually

Level II (National) → HCPCS A-V
Alphanumeric System

Level III (State) → Local Codes W-Z
Alphanumeric System
Current Procedural Terminology

- Chapter 1: Evaluation and Management Codes (99201-99499)
- Chapter 2: Anesthesia codes (00100-01999)
- Chapter 3: Surgery Codes (10040-69990)
- Chapter 4: Radiology Codes (70010-79999)
- Chapter 5: Pathology/Laboratory Codes (80049-89399)
- Chapter 6: Medicine Codes (90281-99199)
- Appendices: Modifiers, Deleted Codes, MCM (edited)
International Classification of Diseases
9th Revision Clinical Modification
(ICD-9-CM)

- Index to Diseases: Volume 2
  - 5 Digit Codes
  - Hypertension 401.9 vs. 405.11 (HTN due to Renal Artery Disease)
  - The ‘Why’ you do what you code in CPT
- Tabular Listing: Volume 1
- V Codes: Supplemental Classification of Factors Influencing Health Status and Contact with Health Services
- E Codes: Supplementary Classification of External Causes of Injury and Poisoning
- Appendices
ICD-9 Practically Speaking

**Event/Exposure**
- i.e. Asbestos exposure

**Final Diagnosis**
- R/O Pulmonary Mass unacceptable
- Symptoms i.e. Hemoptysis
- Past Med. Hx. i.e. Squamous Cell Ca.
- All Related Problems (germane issues)
- Family Med. History i.e. Cystic Fibrosis
CPT, ICD and HCPCS
Alphabet Soup for Providers

**ICD-9-CM**
(Why you do things)
- Published by WHO
- Good through October 2005
- Symptoms vs. Dx
- Specificity a must
- Create Medical Necessity

**CPT**
(What you do)
- Owned by AMA
- Published Annually (4/1/__)
- Specialty Chapters, but Not specialty exclusive
- E&M and Procedural tabular listings
- Exact Descriptor (unlisted)
<table>
<thead>
<tr>
<th>Event/Adoption</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Bills of Mortality (1662)</td>
<td></td>
</tr>
<tr>
<td>WHO Transition to “International Lists of Causes of Death” (1800s)</td>
<td>WHO statistical listing of mortalities &amp; morbidities by 1948</td>
</tr>
<tr>
<td>National Center for Health Statistics Adopts ICD-9 in 1979</td>
<td>ICD-9 is International Classification of Diseases 9th Revision</td>
</tr>
<tr>
<td></td>
<td>Billable: MCCA: 1988</td>
</tr>
<tr>
<td></td>
<td>ICD-9 published by AHA</td>
</tr>
<tr>
<td></td>
<td>ICD Effective: Oct 1</td>
</tr>
<tr>
<td></td>
<td>AHA Controls ICD Coding Conventions</td>
</tr>
</tbody>
</table>

ICD-9 was adopted by the National Center for Health Statistics in 1979. It is published by the American Hospital Association (AHA) and is effective as of October 1, 1988. The ICD-9 system consists of three volumes: Tabular List, Alphabetical Index, and Procedural Codes.
ICD-9 Usage Guidelines (2 of 4)

Nomenclature & Acronyms

• NOS: Not Otherwise Specified
• NEC: Not Elsewhere Classified
• New: ●
• Delta: ►
• Blue: Manifestation Code (secondary only)
• Yellow: Unspecified (4th digit “9” or 5th digit “0”)
• Orange: Non-specific (avoid as stand alone, when able)
• Rubric/Category = First 3 characters before decimal point
ICD-9 Usage Guidelines (3 of 4)

Example A

**ICD Codes In Order of Provider’s Perceived Acuity:**

1. Abscess: 682.3  
2. Acne: 706.1  
3. Warts: 078.10  
4. Psoriasis: 696.1

**Rendered Services:**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Linked ICD to CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. 99213-25 (Level 3, established patient)</td>
<td>1, 2, 3, &amp; 4</td>
</tr>
<tr>
<td>B. 17110 (Any benign lesion destruction)</td>
<td>3</td>
</tr>
<tr>
<td>C. 10060-59 (I&amp;D, Simple)</td>
<td>1</td>
</tr>
</tbody>
</table>
ICD-9 Usage Guidelines (4 of 4)

Example B

<table>
<thead>
<tr>
<th>ICD Codes In Order of Provider’s Perceived Acuity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Otitis   388.70</td>
</tr>
<tr>
<td>2. Cerumen Impaction  380.4</td>
</tr>
<tr>
<td>3. Hearing Loss  389.9</td>
</tr>
<tr>
<td>4. Strep Throat  034.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rendered Services:</th>
<th>“Linked” ICD to CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. 99213-25 (Level 3)</td>
<td>1, 2, &amp; 3</td>
</tr>
<tr>
<td>B. 69210 (Wax removal)</td>
<td>2</td>
</tr>
<tr>
<td>C. 87880 (Rapid Strep)</td>
<td>4</td>
</tr>
<tr>
<td>D. 92557 (Audiometry)</td>
<td>3</td>
</tr>
</tbody>
</table>
ICD-10 Timeline (1 of 2)

• Sep 1992
  – Adopted by WHO (owns copyright)
  – ICD-10 Release in English
• Prototype of US Based ICD-10: 1994
• 1996: HIPAA originally lists ICD-9 as National Standardized Code Set
• 1997: ICD-9 CM to ICD-10 CM Crosswalk
• 1999: US using ICD-10 to report deaths
• 1999: NCVHS promoting transition

Priority Management Group, Inc.
ICD-10 Timeline (2 of 2)

- 2002: Published in 42 languages
  - 138 countries reporting mortality
  - 99 countries also reporting morbidities
- 2003: Draft ICD-10 CM on NCHS web site
- Lobbying *for* (AHIMA/NCVHS) and *against* (most providers & associations)
  - Original Date: 5010 as of 4/1/10 & ICD-10 as of 10/1/11
Rationale for Change to ICD-10

• Outdated ICD-9 (30+ years)
• More specific and accurate capture
  – 17,000 ICD-9 (CM & PCS) codes vs. 155,000 in ICD-10
• Improved ability to measure health care services
• Enhanced ability to conduct public health surveillance
  – Comparability with other nations
• Decreased need for supporting claim documentation
• Alignment with WHO
• Health care initiatives based on faulty data
• Inability of ICD-9 to morph with new and/or changing disease
• Coding entities: Requisite certification?? TBD...
Transition to 5010 (1 of 3)

• ANSI Transaction Version 5010 (v5010) replaces v4010
  – ANSI: American National Standards Institute
  – Electronic Data Interchange (EDI) transactions
• Impacted transaction types:
  – Health Care Claims (format 837)
  – Eligibility Inquiry and Response (format 270/271)
  – Claim Status Request and Response (format 276/277)
  – Enrollment format (format 834)
  – Remittance Advance (format 835)
  – Authorizations (format 278)
  – Attachments (format 275)
• Version 5010: > 850 structural, technical & content changes
• Renovation (v5010) versus mapping/adaptation (v4010)
Transition to 5010 (2 of 3)

• Payer Leadership Essential… they run the show
  – Only they can eliminate proprietary adaption and comply with single, standardized format

• Compliance Timeline (as of 1/16/09 final rule publication):
  – Jan 2010: Level 1 testing (internal payer & provider (e.g., CHC))
  – Jan 2011: Begin Level 2 testing (external payer trading partners (e.g., clearinghouses, provider networks, etc.))
  – Jan 2012: Mandatory implementation

• Benefits:
  – Increase transaction uniformity & efficiency (single standardized method versus v4010 which allowed customized mapping)
  – Support pay-for-performance (ICD-10 specificity)
  – Lead to fewer denials (Cleaner submission = cleaner payments)
Transition to 5010 (3 of 3)

• Center for Information Technology Leadership (CITL) 2001 study
  – Aggregate of payer, hospital & physician practices on administrative overhead:
    • $898 per capita or $253 billion (18% of national health care expenditures)
  – Overhead defined as checking eligibility, processing claims and conducting referral and authorization requests

• “Gartner” (think tank) research estimated implementation costs against potential financial benefits of full v5010 (system wide compliance)
  – Industry wide (payer & provider) net savings:
    • $11.6 billion to $33.8 billion

• “HIPAA v5010: A second chance for the industry to implement transaction standards to reduce costs and increase efficiency.”
  – Healthcare Information and Management Systems Society (HIMSS), February 2009
Timelines for Change

• Initial schedule:
  – 5010: Apr 2010
  – ICD-10: Oct 2011
• Jan 2009 Revised... Federal Register Update:
  – 5010: Jan 2012
  – ICD-10: Oct 2013
• 2010: “To Do” list for providers
  – Transition team development & needs assessment
  – Individual plan creation & Launch
• Jan 2011 Testing of 5010 by CMS
# ICD-9 versus ICD-10... Textbook

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Totals:</td>
<td>14,315</td>
<td>69,101</td>
</tr>
<tr>
<td>Chapters:</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Primarily Numeric</td>
<td></td>
<td>All Alpha-Numeric</td>
</tr>
<tr>
<td>Similarities:</td>
<td>• Alphabetical Index &amp; Tabular List</td>
<td>• Alphabetical Index &amp; Tabular List</td>
</tr>
<tr>
<td></td>
<td>• PCS &amp; CM</td>
<td>• PCS &amp; CM</td>
</tr>
<tr>
<td></td>
<td>• Similar Nomenclature</td>
<td>• Similar Nomenclature</td>
</tr>
</tbody>
</table>

Priority Management Group, Inc.
# ICD-9 versus ICD-10... Structure

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 3-5 characters/digits</td>
<td>- 3-7 characters/digits</td>
</tr>
<tr>
<td>- First three are rubric</td>
<td>- Digit 1 is alpha (A–Z, not case sensitive)</td>
</tr>
<tr>
<td>- Primarily Numeric</td>
<td>- Digit 2 is numeric</td>
</tr>
<tr>
<td>- Except V Codes &amp; E Codes</td>
<td>- Digit 3 is alpha or numeric</td>
</tr>
<tr>
<td>- 4th &amp; 5th digits afford additional specificity (but generalized by comparison to ICD-10)</td>
<td>- Digits 4–7 are alpha or numeric</td>
</tr>
<tr>
<td>- 810.00: Unspecified part of closed fracture of clavicle</td>
<td>- S42.001A: Fracture of unspecified part of right clavicle, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

Priority Management Group, Inc.
Training, Training, Training (1 of 3)

• “Single biggest change to healthcare since the advent of the computer.”
• Dramatic impact due to ICD pervasiveness across business processes
• Who to train
  – Clinicians, clinic support staff, billing, finance, grant-writing
• Resources (Internal and External)
• Volume of training
  – AHIMA: 8-10 hours
  – AMA: 20-80+ hours dependent on role
• Timeline... not too soon but not too late
Training, Training, Training (2 of 3)

• Situational analysis
  – Identify stakeholders
  – Assess impact
  • Assign stakeholder responsibilities to avert issues
  – Formulate strategies and identify goals
  – Create timeline with targets
  – Develop education/training plans for employees at all levels
  – Develop information and technology systems’ plan that includes testing and "go live" dates
  – Plan for documentation changes

NOTE: Adopted from AHIMA’s Sue Bowman’s CMS presentation.
Training, Training, Training (3 of 3)

- Cross Walk (Bi-directional)
  - Compare previous ICD-9 Data to new ICD-10
    » Grants, UDS, Case/Risk Management, etc.
- General Equivalency Mapping (GEM)
  - Mappings will be used to
    - convert and test systems
    - link data in long-term clinical studies
    - develop application-specific mappings
    - analyze data collected during transition period and beyond

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>≈</th>
<th>ICD-10-CM Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>599.7 Hematuria</td>
<td>≈</td>
<td>R31.0 Gross hematuria</td>
</tr>
<tr>
<td>599.7 Hematuria</td>
<td>≈</td>
<td>R31.1 Benign essential microscopic hematuria</td>
</tr>
<tr>
<td>599.7 Hematuria</td>
<td>≈</td>
<td>R31.2 Other microscopic hematuria</td>
</tr>
<tr>
<td>599.7 Hematuria</td>
<td>≈</td>
<td>R31.9 Hematuria, unspecified</td>
</tr>
</tbody>
</table>
Medical Necessity

- A service that is reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member.
  - It can be regional.
  - It can be specialty specific.
  - Should be considered standard of care and not experimental.
  - Service should not be performed for convenience or cosmesis.
Defining Levels of E&M Services

• 7 Components
  – History
  – Examination
  – Medical Decision Making
  – Counseling
  – Coordination of Care
  – Nature of Presenting Problem
  – Time
New vs. Established Patient

• New patient: Any patient who has not received professional services, within the previous 36 months, from a provider within the same group, of the same specialty. (MCM 15502.A)
  – Same Group Practice: One Federal Tax ID No. for all providers; If more than one Fed. Tax. ID, then could consider patient new
  – Professional Services: Phone call, prescription, hospital or office visit, etc. . . As of 2002, per CMS, must be a billable service/procedure.
  – Specialty Issue: Optional if one Federal Tax ID No. is shared by practitioners of different specialties (i.e. F.P. and I.M. within same group practice)
The Constants of Coding

• 3 of 3 Rule
  – Go to the lowest component
    • i.e.: 2, 3, 4 = 2 or 3, 3, 4 = 3
  – Used for new patient, initial consults, initial hospital care, and emergency dept. visits

• 2 of 3 Rule
  – Go to the middle component
    • i.e.: 2, 3, 4 = 3 or 3, 3, 4 = 3
  – Used for established patient, subsequent hospital f/u, f/u consult
History

- Chief Complaint Required
- History of Present Illness (HPI)
  - CPT Definition Brief: 1-3 Elements
    - *Extended: ≥ 4 Elements

<table>
<thead>
<tr>
<th>The Elements (Table 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Quality</td>
</tr>
</tbody>
</table>

*PMH ≥ 3 germane items for 1997 system
36 yo BF c/o LBP. Right paralumbar x 24 hours. Tylenol and ice helped. Worse today. Denies W/A, NSD, BBI
A History Example

6 yo BF c/o otalgia. AD x 24 hours. Tylenol helped. Worse today. No F/C, N/V/D, Exanthem.
History

- Review of Systems (ROS)
  - Problem Pertinent: 1 Element
  - Extended: 2-9 Elements
  - Complete: 10 Elements

The Elements (Table 2)

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Respiratory</th>
<th>Skin</th>
<th>Hematologic &amp; Lymphatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Gastrointestinal</td>
<td>Neurologic</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>Genitourinary</td>
<td>Psychiatric</td>
<td>Allergic &amp; Immunologic</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Musculoskeletal</td>
<td>Endocrine</td>
<td></td>
</tr>
</tbody>
</table>
History

• Past Family, Social (Medical) History (PFSH)
  – Pertinent: 1 from any PFSH area
  – Complete: 2 if Established, 3 if New Patient
## History Algorithm

**Table 3 using 3 of 3 Rule**

<table>
<thead>
<tr>
<th>History Type</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (1)</td>
<td>Brief</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Expanded Problem Focused (2)</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>None</td>
</tr>
<tr>
<td>Detailed (3)</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive (4)</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>
A History Example

36 yo BM c/o LBP. Right paralumbar x 24 hours. Tylenol and ice helped. Worse today.

ROS: Denies W/A, NSD, BBI.

PMH/FMH: NC

Soc: Builds rock walls for stress relief
A Detailed History

67 yo WM c/o CP x 24 hours. Left midsternal pressure. 2-3’ last night with exertion. Now 15-20’ w/o exertion and stabbing with residual pressure. SL NTG stopped it last night, now persisting. Here via EMS.

ROS: +N/V, LUE Pain. No diaphoresis, neck/jaw pain

FMH: Mother/Father CAD

PMH: CAD hx. S/p CABG 2 years ago

Social: 2 PPD x 6 mo. Wife died 6 months ago.
A History Example

6 yo BF c/o otalgia. AD x 24 hours. Tylenol helped. Worse today.

ROS: No F/C, N/V/D, Exanthem.

PMH/FMH: NC

Soc: Nonsmoking household
Physical Examination

• Problem Focused Exam (1)
  – 1995: < 1 Organ System/Body Area
  – 1997: 1-5 Bulleted Elements

• Expanded Problem Focused Exam (2)
  – 1995: 2-4 Organ Systems/Body Areas
  – 1997: ≥ 6 Bulleted Elements
Physical Examination Cont’d.

- **Detailed Exam (3)**
  - 1995: 5-7 Organ Systems/Body Areas
  - 1997: $\geq 2$ Bulleted Elements from 6 Areas
    OR
    $\geq 12$ Bullets from $\geq 2$ Areas

- **Comprehensive (4)**
  - 1995: $\geq 8$ Organ Systems/Body Areas
    OR
    Complete Single System Examination
  - 1997: $\geq 2$ Bulleted Elements from 9 Areas
Detailed Examination

- WDBM in NAD
- Eyes: PERRLA/EOMI
- Neck: No goiter/rigidity
- Lymph: No SC, IC, axillary nodes
- Skin: No periorbital, malar or palmar lesions/exanthems
- Neuro: CN II-XII grossly intact; DTR +2/4 UE/LE
- Ext: Equal Strength & tone
- MS: Gait stiff and antalgic

- Ant. Rot. Outflared right ilium. L on L torsion with L5-S1 compensatory changes and lower leg length discrepancies
Comprehensive Exam Example

Const: WDWM in NAD
Neuro: A&O x 3
Neck: Supple w/o goiter
Eyes: PERRLA w/ EOMI
ENT: Unremarkable
CV: RRR +S1,2 w/o S3, 4 or Murmur. No JVD
Lungs: CTA w/o W/R/R
Abd: Soft, NT +BS w/o guarding
Comprehensive Exam Example

Const:  WDBF in NAD, nontoxic
Neuro:  A&O x 3
Lymph:  Right anterior cervical adenopathy
Eyes:  PERRLA w/ EOMI
ENT:  AD TM bulging, erythematous, AU EAC and AS TM normal
CV:  Regular w/o murmur
Lungs:  Clear
Skin:  No exanthem
# Medical Decision Making:
## Diagnoses/Management Options

**Table 4 (Maximum of 4 points)**

<table>
<thead>
<tr>
<th>Problem Categories</th>
<th>Number of Problems</th>
<th>Possible Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited/minor</td>
<td>Maximum of 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem -stable or improving</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem -worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New Problem (no further work-up)</td>
<td>Maximum of 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New Problem (work-up needed)</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Decision Making:
#### Amount and Complexity of Data

Table 5 (Maximum of 4 points)

<table>
<thead>
<tr>
<th>Type of Data</th>
<th>Check if Done</th>
<th>Possible Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/Order Test(s) (8XXXXX Clinical)</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review/Order Test(s) (7XXXXX Radiology)</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review/Order Test(s) (9XXXXX Medicine)</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discuss test results w/ performing physician</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Independent review of tracing, specimen, image</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Decision to obtain medical records</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review, summarize old records and/or obtain hx.</td>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
# Medical Decision Making: Final Medical Decision Making

## Table 7 (2 of 3 Rule)

<table>
<thead>
<tr>
<th>Decision Making</th>
<th>Straight Forward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis &amp;/or Management Options</td>
<td>Minimal (1)</td>
<td>Limited (2)</td>
<td>Multiple (3)</td>
<td>Extensive (≥4)</td>
</tr>
<tr>
<td>Amount of Data Reviewed</td>
<td>Minimal/None (1)</td>
<td>Limited (2)</td>
<td>Multiple (3)</td>
<td>Extensive (≥4)</td>
</tr>
<tr>
<td>Table of Risk</td>
<td>Minimal (1)</td>
<td>Low (2)</td>
<td>Moderate (3)</td>
<td>High (4)</td>
</tr>
</tbody>
</table>
### Established Patient CPT E&M Guidelines (2 of 3 Rule)

#### Table 9

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Focused (1)</td>
<td>Problem Focused (1)</td>
<td>Straight Forward (1)</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded Problem Focused (2)</td>
<td>Expanded Problem Focused (2)</td>
<td>Low complexity (2)</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed (3)</td>
<td>Detailed (3)</td>
<td>Moderate complexity (3)</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive (4)</td>
<td>Comprehensive (4)</td>
<td>High Complexity (4)</td>
<td>40</td>
</tr>
</tbody>
</table>
Rules for Consultation

99241-99255

1. Opinion or advice regarding E&M of a specific problem is requested.

2. Documented request from appropriate source is required

3. Written report sent to referring provider (a letter for an outpatient). Standardize.

4. Initiation of care at time of consult is acceptable.

5. January 1st 2010 No Consults Medicare/Tricare
<table>
<thead>
<tr>
<th>Table 8 Confirmatory</th>
<th>Initial Consult</th>
<th>New Patient</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99271 GONE</td>
<td>99241</td>
<td>99201</td>
<td>Problem Focused (1)</td>
<td>Problem Focused (1)</td>
<td>Straight Forward (1)</td>
<td>10</td>
</tr>
<tr>
<td>99272 GONE</td>
<td>99242</td>
<td>99202</td>
<td>Expanded Problem Focused (2)</td>
<td>Expanded Problem Focused (2)</td>
<td>Straight Forward (1)</td>
<td>20</td>
</tr>
<tr>
<td>99273 GONE</td>
<td>99243</td>
<td>99203</td>
<td>Detailed (3)</td>
<td>Detailed (3)</td>
<td>Low Complexity (2)</td>
<td>30</td>
</tr>
<tr>
<td>99274 GONE</td>
<td>99244</td>
<td>99204</td>
<td>Comprehensive (4)</td>
<td>Comprehensive (4)</td>
<td>Moderate Complexity (3)</td>
<td>45</td>
</tr>
<tr>
<td>99275 GONE</td>
<td>99245</td>
<td>99205</td>
<td>Comprehensive (4)</td>
<td>Comprehensive (4)</td>
<td>High Complexity (4)</td>
<td>60</td>
</tr>
</tbody>
</table>
Coding Matters

- Consults OK for nonCMS patients
- No facet injections without CT/fluoroscopy
  - Consider peripheral nerve blocks, ligaments, tendons, joints
  - Ultrasound!!!!
- Preventive Exams (kids too) 10 ROS and multisystem exam PLUS E&M (-25 modifier) prn
- Document what you do and get paid for it
- Be as specific as possible in choosing ICD codes (5 digits first)
Code Utilization by Practice

- 99211 = 1%
- 99212 = 8.6%
- 99213 = 38.4%
- 99214 = 30%
- Prevention = ~20%
Summary

• ICD to Support CPT
• Proper Documentation
• Team Approach
• Compliance Recommendations
• Critically Review and Update E&M Implementation Policies
• Stay Current: Education, Education, Education!
Thank you!
Thank you!
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong> (1)</td>
<td>- One self limited or minor problem; e.g.: cold, tinea, insect bite</td>
<td>- Labs requiring venipuncture. - Chest X-ray - EEG/EKG - Urinalysis - Ultrasound/Echo - KOH Prep</td>
<td>- Rest - Gargles - Elastic bandages - Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong> (2)</td>
<td>- Two or more self limited or minor problems - One stable chronic illness; e.g.: well controlled HTN, NIDDM, BPH, cataract - Acute uncomplicated illness or injury; e.g.: cystitis, allergic rhinitis, simple sprain</td>
<td>- Physiologic tests not under stress; e.g.: PFT - Non-CV imaging studies w/ contrast barium enema - Superficial needle biopsies - Skin biopsies - Labs requiring arterial puncture</td>
<td>- Over the counter drugs - Minor surgery w/out risk factors - Physical Therapy - Occupational Therapy - IV fluids w/out additives</td>
</tr>
<tr>
<td><strong>Moderate</strong> (3)</td>
<td>- One or more chronic illnesses w/ mild exacerbation, progression, or side effects of treatment. - ≥2 stable diagnosis - Undiagnosed new problem e.g.: Breast lump. - Acute Illness w/ systemic symptoms; e.g.: pyelonephritis, colitis, pneumonitis - Acute, complicated injury; e.g.: head injury w/ brief LOC</td>
<td>- Physiological tests under stress; e.g.: ETT, Fetal Contraction Stress Test - Diagnostic Endoscopy w/out risk factors - Deep needle or incisional biopsy - CV imaging studies w/ contrast and no identified risk factors; e.g.: arteriogram, cardiac catheterization - Obtain fluid from body cavity; e.g.: LP, culdocentesis, thoracocentesis</td>
<td>- Minor surgery w/ identified risk factors - Elective major surgery (open, percutaneous or endoscopic) w/out risk factors found. - Prescription drug management - Therapeutic nuclear medicine - IV Fluids w/ additives - Closed treatment of fractures or dislocation w/out manipulation</td>
</tr>
<tr>
<td><strong>High</strong> (4)</td>
<td>- One or more chronic illnesses w/ severe exacerbation, progression or side effects. - Acute or chronic illnesses or injuries that pose a threat to life or bodily function; e.g.: multitrauma, MI, PE, Psychiatric emergency, Progressive sever RA, ARF, Peritonitis - Abrupt change in neuro status; e.g.: seizure, TIA, weakness or sensory loss.</td>
<td>- CV imaging studies w/ contrast w/ identified risk factors. - Cardiac EPS - Diagnostic endoscopy w/ identified risk - Discography</td>
<td>- Elective major surgery (open, percutaneous or endoscopic) w/ identified risk factors - Emergency major surgery (open, percutaneous or endoscopic) - Parenteral controlled substances - Drug Therapy requiring intensive therapy for monitoring - Decision to make DNR/DNI or de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>