

ICD-10 IN 2015: A YEAR OF TRANSITION



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As 2015 kicks off, healthcare is poised to see a plethora of changes and providers will need a scorecard to keep up. January 1, 2014 saw almost 550 new, changed and deleted codes in AMA's CPT codes. The number is larger than in previous years and particularly impacts services in the family practice, internal medicine, cardiovascular, gastrology, pathology/laboratory, and radiology areas. Seven changes were made to the evaluation and management (E/M) section, the most often reported codes in the service-oriented code set. These CPT changes as well as the new ICD-10 code-set scheduled to take effect October 1, 2015 will make for trying times for all providers regardless if practice or hospital-based.

Many practices are still skeptical about whether the conversion to the new ICD-10 code set will actually happen come October. Although previous deadlines were moved "to allow insurance companies and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready," the U.S. Department of Health and Human Services has dubbed further delay of ICD-10 a myth. They have announced "no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2015."

So where does that leave providers and their practices? Many practices, after the delay in 2014, have put the brakes on ICD-10 training and testing for several reasons. One, they adopted the wait-and-see attitude. Two, they exhausted their financial resources in getting ready for the first conversion date and their budget didn't allow for the additional costs involved with the delay. Three, they were ready for the October 1, 2014 deadline, and they just stopped where they were.

If your practice is in the wait-and-see mode, this is not a great place to be. CMS has made it clear the conversion will take place in 2015. Unfortunately, too many practices fall into this category but with some simple steps, a practice can get back on track for a smooth conversion.

First, talk to your practice management vendor and find out where they are in the transition to ICD-10. Most should be ready to roll, which is good, but testing is a must. CMS is still seeking practices to volunteer for testing. It is never too soon to test the practice management system and EHR to make sure the transition will go smoothly.

Secondly, plan financially for that rainy day, which may be

the month of October in the coming year. Many experts are indicating that practices need to have at least two or three months of cash on hand, in the event that claims are slow to be processed. A practice cannot afford to be ill-prepared should revenue stream slow to a trickle. With everyone converting at once, claims will, more than likely, be delayed in processing. The premise of the initial conversion delay was to ensure that carriers as well as providers would be ready, but the reality is some will not be ready. At this point, it is still unclear if all carriers will be required to convert to ICD-10.

Lastly, but certainly not the least, start reviewing clinical documentation. The "buzz words" this past year have been "Clinical Documentation Improvement." Improvement in documentation will never be wasted time, even if we see ICD-10 delayed again. The changes that we see in ICD-10 affecting provider documentation are things such as laterality (right or left) and sequela (first episode or subsequent). Many diagnosis codes now have bundled codes, so specificity is key. The specificity changes in the code set will require providers to be clear and concise in their documentation. Such words as "and" may need to be replaced with terms such as "with" and "due to" to accommodate for these new combination codes.

Other trends we should see this year are the proliferation of different methodologies for payment. We have heard about many providers who are leaving the traditional fee-for-service models and venturing into patient-centered medical homes, accountable care organizations and shared savings plans. Improved documentation is vital for providers who may wish to change their payment model and be successful in doing so. Patient care affects the reimbursement rates within the new models. Therefore, better documentation and capturing of patient data will allow a provider to be successful with one of these new emerging payment models.

Insurance carriers that ventured into new arenas of payment such as Medicare Advantage programs are seeing many changes taking place with respect to data collection, coding, and billing. Some of the most significant transformations in the history of the Medicare Advantage industry makes it more critical than ever for physicians to put enhanced focus on not only the accurate and timely capture of data, but also on tracking a patient's care and condition over time.

I feel as though we should call this "year of transition" the "year of education" instead. I see providers needing to educate

themselves about which electronic record to use, different practice management systems, on improving their clinical documentation, ICD-10 code-set conversion, cash flow during the conversion, new CPT codes, and on how to research new payment models. Providers, now more than ever, will need to embrace change and

make informed decisions about their practices. While many will still speculate about whether ICD-10 will actually be implemented, improving clinical documentation now, rather than later, will benefit a practice in multiple ways and may prove to be time worthy. +

E-CIGARETTES ... (Continued from p. 25)

among the study subjects who used the e-cigarettes.

The World Health Organization (WHO) also has its concerns about use of the e-cigarettes. WHO states on its website, "This illusive 'safety' of Electronic Nicotine Delivery Systems can be enticing to consumers; however, the chemicals used in electronic cigarettes have not been fully disclosed, and there are no adequate data on their emissions."

The electronic cigarette has four ingredients: nicotine, propylene glycol, vegetable glycerin and flavoring. Tobacco is not included. Beyond the four main ingredients, some researchers are concerned with the byproducts from the heat source and the solution contained within the device. Several studies have suggested the vapors of e-cigarettes can contain microscopic particulate matter, tin, chromium, nickel and other heavy metals, which can cause pulmonary pathology.

With an e-cigarette, the user inhales a vaporized liquid nicotine instead of the tobacco smoke that would be inhaled from a conventional cigarette. This is the alternative that is touted as "healthy" or less harmful. The process of smoking an e-cigarette is called "vaping." Nicotine addiction, as most other addictions, is cue driven. The activity of using an e-cigarette is a powerful cue as it mimics the behavior, the actual activity of vaping.

The unregulated and unrestricted availability of highly concentrated electronic nicotine delivery systems has led to increased exposure and potentially significant nicotine toxicity. This is confirmed by the National Poison Data System, which reported triple the number of childhood exposures to nicotine in 2013 compared with 2012.

Nicotine is a plant derived parasympathomimetic alkaloid. Nicotine is essentially a highly agonist of the nicotinic acetylcholine receptors. Nicotine stimulates the reticular activating system in addition to stimulating a dopamine release. Emerging research also links nicotine to impairment of the immune system. With dosage increase of nicotine, cardiovascular effects can occur,

including tachycardia and hypertension, gastrointestinal disturbance and at toxic levels neuromuscular blockade and central nervous system toxicity.

As physicians and healthcare professionals, especially addiction medicine specialists, what are our reactions and responses to our patients, community members, colleagues, and family when we are asked about electronic cigarettes? It seems reasonable that we continue to advise any current non-tobacco user to not start and not consider trying any of the currently available methods of using nicotine. We should consider this as we advise our patients regarding opiates, benzodiazepines, alcohol and other risk behaviors.

How do we respond to a current patient who's considering cessation? Is this an opportunity to discuss life change with our patient? When a patient inquires about my opinion regarding e-cigarettes, it is an opportunity to begin discussing a goal of nicotine cessation and developing a treatment strategy.

A recent survey of North Carolina physicians published in *PLOS ONE*, measured physicians' attitudes toward e-cigarettes use by adult smokers. "Even in the absence of evidence regarding the health impact of e-cigarettes and other vaping devices, a third of physicians we surveyed are recommending e-cigarettes to their patients to help quit smoking," said Leah Ranney, PhD, one of the authors of the survey. "Yet, e-cigarettes are not approved by the FDA for smoking cessation."

Clinically, with each patient encounter, I remember, first do no harm...

Recently, we added to our patient intake forms these questions:

1. Do you use electronic cigarettes? *Yes/No*
2. If yes, is it part of your plan to taper or quit smoking?
Yes/No/Not sure

With any patient encounter I want to maintain the patient's respect and trust in my providing guidance to healthy life choices. One of my goals is to help the patient attain his or her full potential. +