Getting ready for ICD-10 by 2013

ICD-9 is more than 30 years old and outdated. Its successor will reflect advances in medicine and be a boon to research and public health, -- but the transition will be a burden for physicians.

ICD-10 is slated to succeed ICD-9 effective October 1, 2013, as the HIPAA-required system for coding diagnoses in all clinical settings and for hospitals to report inpatient procedures. (CPT will remain the coding system that doctors use to report services and procedures, regardless of setting.)

The U.S. Department of Health and Human Services (HHS) is mandating the change because ICD-10 better reflects current medical knowledge and technology and also permits greater specificity in coding and reporting diagnoses and procedures. Consequently, ICD-10 will provide a more consistent and logical framework and yield better data to support public health surveillance and research.

The differences between ICD-9 and ICD-10 are substantial, and therefore the transition is certain to be burdensome for physicians. Practice management staff and physicians should begin taking steps now to prepare for the October 2013 compliance date.

AMA and RIMS advocacy
HHS initially called for a much tighter compliance date of October 1, 2011, for nationwide implementation of ICD-10.

In 2008, RIMS joined the AMA and other medical organizations in calling for a revision of that timetable. The physician groups argued that CMS underestimated the time and expense involved in retraining and retooling from a system of about 16,000 procedure and diagnosis codes to a new system of 155,000 codes. In January 2009, HHS relented, pushing the deadline back by two years to October 1, 2013.

Besides extending the

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Liability notes:
Rhode Island and the federal “demonstration projects”

When U.S. Senator Sheldon Whitehouse addressed the RIMS Council on August 17, 2009, physician members of the Council repeatedly expressed their disappointment and incredulity that health system reform efforts in Washington allegedly aimed to control costs but were perversely ignoring a major driver of unproductive expense in American health care: liability and defensive medicine.

Three weeks later, in his September 9, 2009, address to a joint session of Congress, President Obama announced a new federal program of liability “demonstration projects,” the purpose of which would be to identify and measure effective strategies to improve the liability system in ways that would better serve patients, reassure doctors and save the system money as a result.

Presidential recognition that the liability system might be a major part of the problem was encouraging. Add the promise of a new opportunity, supported with government funding, to demonstrate better models, and the message was more encouraging still. Yet one had to reflect: we already have lots of data on what works and does not work in liability. For example, California’s successful “demonstration project” has been running for 34 years. Many other states have long been “laboratories of democracy” for testing various kinds of liability reforms.

Nevertheless, the health care community can hardly fail to respond to the President’s challenge and must seek to make the most of it.

Accordingly, on September 10, 2009, the Rhode Island Medical Society (RIMS) and the Hospital...
Inaugural remarks of Dr. De Palo delivered at the Dunes Club on September 26, 2009

Medicine is changing. It has always been changing. In fact, change is what advances us. Sometimes, the pace of that change can be unsettling. For years, the changes have included additions to our knowledge base or to our skill set. The options of diagnostics and therapeutics in medicine and surgery are much different today than they were 30 years ago. In the last few years however, the changes really have focused on our system.

How do we deliver care? Is it the best care possible? Is it the care that has been proven to give the best outcomes? Is it efficient? Is it affordable?

Well, we stand at the edge of the precipice. To use a metaphor from this lovely location, we are riding the crest of a wave. There is much discussion of what health care will look like in the future. Many in this room and in our society have risen to the challenges through the year and have led us along the bumpy road of health care. We have collaborated for quality. We continue to do so. It is time that we collaborate for system change. It will be with the insight and wisdom of our past presidents, our health care leaders, our partners and collaborators, that we will enrich the debate and bring us to a better system of care for all.

But this will not come easily. It comes with hard work and attention to detail. Communication is key. It is with communication and collaboration that not only will we continue to bring about knowledge base, technology, and quality advancements, but together we will help to shape our health care delivery system.

During this past week, I had conversations or communications from several past presidents. I will mention two. The first was a conversation with Dr. Bud Kahn at the Medical Society Golf Tournament. He took me aside to tell me about his presidency year. He told me what a wonderful year it was and that I would get to work with an amazing staff. The second was a note from Dr. Ric Christian. Ric told me what an exciting and professionally satisfying year he had. Both told me how hard it was and were full of words of support and encouragement.

Well, I agree with them. The staff at the Rhode Island Medical Society is an amazing staff. I have gotten to know them this year. I am looking forward to working closely with them during the next year. To my colleagues, my partners, my collaborators, and to my friends, I look forward to working together with you.

The challenges will be great, and I will surely need everyone’s help. This is our opportunity to contribute to the discussion which will shape the health care landscape. It will be with communication, collaboration and focus on the noble profession in which we are committed that we will make our greatest impact! Thank you.

FROM THE PRESIDENT

Regional variations in Medicare payments

If there is one thing that physicians of all specialties and in all parts of the country might agree upon, it is that Medicare payments for physician services are inadequate and are becoming more so each year. – even without the periodic threat of catastrophic cuts like the 21.2% drop that is looming on March 1, 2010. In particular, physicians in Rhode Island and in certain other parts of the country, especially in rural areas, often voice the impression that Medicare’s Resource-Based Relative Value Scale (RBRVS) short changes them to an even greater extent than it does other physicians who are fortunate enough to practice elsewhere. Rhode Island physicians often assume that the discrepancies in commercial insurers’ treatment of physicians within New England are reflected equally greatly in Medicare, though this is quite certainly not the case. Some physicians seem to conflate Medicare’s payment policy with a comparative survey of Medicaid fee-for-service rates that was published by RIEPC in 1994 – before RiteCare – and showed Rhode Island next to the bottom nationally.

The RBRVS, developed at Harvard in the 1980s and implemented by Medicare in the early 1990s, is far from perfect. It has probably not served the country well (some say its overemphasis on clinical effort and its undervaluation of effect have helped to undermine primary care) and is likely to be substantially modified or supplanted in coming years. For all its shortcomings, RBRVS is not static and is designed to be self-correcting, to an extent. For example, the RBRVS is systematically updated and modulated to reflect geographic changes and differences in living costs and in the prevailing value of professional work in different parts of the nation. As a result of these modulations, Rhode Island physicians today are paid about 12% more than Arkansas physicians, about 6.6% less than Connecticut physicians and about 11% less than physicians in metropolitan Boston. The differences arise mainly from the federal government’s measures, which are updated every three years, of living costs in the various markets as an index to differing overhead expenses for medical practices.

Below is a more detailed explanation of how these calculations come about. Medicare payment to doctors everywhere in the U.S. is a product of the following three factors: 1) a nationally uniform RBRVS, 2) a set of Geographic Practice Cost Indi ces (GPCI) that modulate the RVUs (Relative Value Units) to reflect local economic conditions, and 3) a nationally uniform Conversion Factor (CF), which is currently $36.08.

Let us take a closer look at the first two factors. The nationally uniform RBRVS assigns a relative value to each of the thousands of discrete services identified by the CPT coding system. The relative value of each service is expressed as a number, which is the sum of the RVUs that Medicare assigns for each of three components of every service: the value of the work involved (time, intensity, skill, training, experience, etc.), the general practice overhead expense (office rent, personnel, utilities, equipment, supplies etc.), and the medical professional liability insurance expense that can be allocated to the service.

The weight given to overhead and liability varies slightly from code to code, but overall in the RBRVS system the “work” component accounts for 52% of RVUs, general overhead accounts for 44% of RVUs and liability expense for only about 4% of RVUs.

The RVUs assigned to each of the three components (work, overhead, liability) of each CPT service are multiplied by a geographic adjustment factor that is specific to that component and to that geographic area or “locality.” Medicare divides the nation into 89 “localities.” Rhode Island and Connecticut are each a single locality. Massachusetts is two localities, namely “Metro Boston” and “the rest of MA.” Every three years, Medicare measures the going rates for professional work, for living costs/practice overhead, and for medical professional liability insurance in each locality and updates the geographic adjustment factors accordingly.

The three geographic adjustment factors compare each locality with the rest of the country. That is to say, an adjustment factor of “1.00” corresponds to what Medicare
Considerers to be the national average and results in no adjustment in payment. A factor >1.0 means the value is above the national average and this higher factor results in a higher payment. A factor <1.0 means the value is below the national average and this lower factor results in a lower payment.

These three adjustment factors are called Geographic Practice Cost Indices or GPCIs. Medicare assigns each locality its own three GPCIs [one for work, one for practice overhead and one for liability cost], in order to account for regional differences and thus make the RBRVS payment system fairly to doctors everywhere.

The formula for payment for each service would look like this:

\[ CF = \text{work RVUs} \times \text{work GPCI} + \text{office rent RVUs} \times \text{overhead GPCI} + \text{liability RVUs} \times \text{liability GPCI} \times CT \]

Where:
- \( CF \) = Payment
- \( CT \) = Payment
- RVUs = Resource-based Relative Value Units
- GPCI = Geographic Practice Cost Indices
- CT = Payment

How Rhode Island stacks up
Rhode Island’s current GPCI for the “work” component is 1.029; thus, it is above the national average and is identical, in fact, to the work GPCI for Connecticut. The rest of MA, at 1.017, is lower than Rhode Island, CT, at 1.038; for both higher than both Rhode Island and Metro Boston.

Rhode Island’s “overhead” living expense GPCI of 1.04; Metro Boston’s is 1.311, and the rest of MA is 1.106. CT’s is 1.179. Apparently, then, Medicare finds RI’s overhead costs (office rent, etc.) are generally lower than those in MA and CT but still higher than the national average. The overhead RVUs in RI are 0.846. Thus, Medicare finds RI’s liability expense to be below the national average but higher than that of Metro Boston and the rest of MA, which are both pegged at 0.787, and also higher than CT at 0.934.

To compare Medicare’s overall physician payment levels in RI, MA and CT, we have to take into account the different weighting of the three factors (52% work, 44% overhead, 4% liability expense). Doing so, we can arrive at a rough composite geographic adjustment factor for RI of 1.0052, for CT of 1.0558, and for Metro Boston of 1.14540.

[Note: These “composite” factors are generated by RMS and are not known to be calculated or used by Medicare in any way.] It follows that Medicare pays doctors in all three states at rates that are above Medicare’s national average.

Because the actual weighting varies slightly from code to code, these calculated composites are not precise, but they suggest that Medicare pays Metro Boston physicians at rates about 11% higher than what RI physicians receive, and that Medicare pays CT physicians at a rate about 6.6% higher than what it pays RI physicians. These differences in payment rate are not insignificant, but they are narrower than many Rhode Island physicians may believe them to be. (Rhode Island physicians may tend to generalize from the commercial side, where the discrepancies have been much greater, as the Massachusetts Medical Society’s study released in 2003 demonstrated.)

For comparison’s sake, add Arkansas to the mix:

A state where the three components of RBRVS are lower provides some additional perspective on the range of payment differences that exists within the Medicare system. Arkansas, like CT and RI, is a single “locality” in Medicare’s payment system. AR’s GPCIs are 1.0 for professional work (thus, neither higher nor lower than the national average), 0.846 for office rent, and 0.436 for liability insurance expense (well below the national average), which would yield a composite geographic adjustment of about 0.9108. From this calculation, one can infer that Medicare pays AR doctors at rates that are about 12% less than the national average.

Thus, for RI physicians, something has happened to provide physicians with a clearer picture of how Medicare will be paying them in 2010. Physicians will then have until March 17 to consider whether to change their participation status. Any change, however, will be retroactive to January 1. That means, for example, that in the unlikely case that a physician opts to change from non-participating to participating, he or she might have to refund to Medicare any dollars that had been balance billed to patients since January 1, 2010.

Will you be ready for PECOS by April 5?

An understated communications effort by CMS has left some medical practices in the dark about a looming deadline that could confront some doctors with a string of Medicare claims rejections starting April 5, 2010.

In a nutshell: all ordering and referring physicians must be enrolled in the Medicare Provider Enrollment and链转与Ownership System (PECOS) by April 5 of this year, or their claims will no longer be paid. [This requirement was originally slated to go into effect on January 4, 2010, but the deadline was extended when CMS was unable to implement the system by that date. During the current phase-in period, physicians who are not enrolled or whose enrollment record in PECOS are being processed for the first time, by May 1, will still be allowed to receive Medicare payments. However, physicians who are not enrolled or whose enrollment record in PECOS are approved by May 1, will be automatically rejected. Thus, by March 1 at the latest, something will have happened to provide physicians with a clearer picture of how Medicare will be paying them in 2010. Physicians will then have until March 17 to consider whether to change their participation status. Any change, however, will be retroactive to January 1. That means, for example, that in the unlikely case that a physician opts to change from non-participating to participating, he or she might have to refund to Medicare any dollars that had been balance billed to patients since January 1, 2010.]

They must also mail any support documentation that may be required, such as IRS CP-575 (the form that documents one’s employer identification number) or CMS-888 (the form that authorizes electronic funds transfer). Before mailing, one should check to make sure that CMS provided the correct mailing address to the Medicare Provider Enrollment and链转与Ownership System (PECOS) service. One can call 1-800-650-4626 or 1-800-638-9046 for more information on how to update their Medicare participation status. The new deadline is March 17. If one does not have these, one can call the CMS Help Desk for “External User Support” at 1-866-484-8049 Monday through Friday between 7am and 7pm EST or email EUSSupport@cgib.com.

Physicians can also contact Deanna Batstone at NHIC, Corp. (781-741-3479 or deanna.batstone@edcs.com) for information on PECOS.

Physicians who prefer not to work online with PECOS may update, enroll or re-enroll by completing and submitting a hard copy of CMS Form 855.
ICD-10 – continued

ICD-10 deadline, CMS also delayed until January 1, 2012, the deadline for doctors to adopt the 5010 electronic transaction standards under the Health Insurance Portability and Accountability Act.

Major differences between ICD-9 and ICD-10

Compared with ICD-9, the ICD-10 system involves longer codes (more characters per code) and an explosion in the overall number of codes. More specifically, while there are currently some 14,000 ICD-9-CM diagnosis codes, each one of which is 3 to 5 characters in length, the ICD-10-CM system has 68,000 diagnostic codes of 3 to 7 digits in length. The expanded characters of ICD-10-CM permit greater detail in reporting disease etiology, anatomic site and severity.

The increased number and length of the codes will require medical offices to invest in planning, training, and upgrades of their software and perhaps hardware. In particular, the administrative transactions software required by HIPAA will have to be upgraded from version 4010 to version 5010 in order to accommodate the longer codes and expanded data fields.

The upgrade to 5010 transactions must precede the implementation of the ICD-10 code sets. HMS has set a compliance deadline of January 1, 2012, for implementation of 5010 transactions.

The National Center for Health Statistics (NCHS) maintains the ICD-10-CM code set for diagnoses and ICD-10-PCS code set for procedures and these sets files available on its website: www.cdc.gov/nchs/icts/icd10.htm.

The American Medical Association’s website (ama-assn.org) is an invaluable source for ongoing information on ICD-10. Among the resources currently available there is the AMA’s 11-page guide to “Preparing for the Conversion from ICD-9 to ICD-10: What You Need to Be Doing Today” (ama-assn.org/go/hippa).

This AMA document provides practical advice on taking the following steps:
1) Identify the electronic and manual systems and work processes in which your practice currently uses ICD-9.
2) Consult with your practice management service.
3) Consult with your clearing houses or billing service, if any, and with payers.
4) Consult with your payers regarding possible changes to your contracts as a result of ICD-10 implementation.
5) Identify potential changes to existing practice work flow and business processes.
6) Identify staff training needs.
7) Test with your trading partners (payers and clearinghouses).
8) Budget for implementation costs (system changes, resource materials, consultants, training).

More background and a little history

ICD-10 includes ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) and ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedure Coding System).

ICD-10-CM is the code set for reporting diagnoses in all clinical situations, it is the updated version of ICD-9-CM Volumes 1 and 2. ICD-10-PCS is the code set used only by facilities for reporting inpatient procedures. It is the updated version of ICD-9-CM Volume 3.

The implementation of ICD-10-PCS may lead hospital coders to ask doctors to provide more detail in operative notes, but otherwise should have little or no impact on physicians. CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) will continue to be the code sets that doctors will use for reporting procedures in all settings.

Both ICD-9 and ICD-10 were developed by the World Health Organization. ICD-9 has been widely used in the U.S. since 1978. The WHO endorsed ICD-10 in 1990, and many countries have already adopted versions of it.

Federal demonstration projects – continued

Association of Rhode Island (HARI) and Quality Partners of Rhode Island (QPRI) began working together to prepare for the Washington rollout of the specifics of the Obama Administration’s newly announced program. It was quickly apparent that Rhode Island would have plenty of material to work with in making a case for a demonstration project, or at least for a planning grant. For one thing, the state is close to being a tabula rasa for liability reform, and therefore the results of any experiment would be complicated by fewer variables. In addition, groups in Rhode Island had recently put in huge amounts of highly sophisticated and successful work in such areas as ICU safety, wrong-site surgery, the medical home model, e-prescribing, HIT and others.

When the U.S. Department of Health and Human Services (HHS) released the parameters of the administration’s plan, it was unclear whether organizations like RIMS, HARI or QPRI could actually apply to offer for the new federal funds. (The pot of funding, it turned out, would amount to only $25 million nationwide, for which the competition is likely to be fierce.) Direct discussions with HHS clarified that neither RIMS, nor HARI nor QPRI could qualify to apply for the program. Indeed, only an integrated health system or an agency of state government would be eligible. RIMS, HARI and QPRI therefore next approached the Rhode Island Department of Health and offered to perform the work of applying for the funding and of executing the project if the department would only sponsor the effort and lend its name to it. The Department declined, credibly citing its acute lack of resources.

Meanwhile, Mary Cooper, MD, JD, a Lifespan Vice President, was the similar quest. Lifespan itself, with its member hospitals and its captive liability insurer (Rhode Island Sound Enterprise, or RISE), has all the attributes and components to be a credible applicant. Moreover, Dr. Cooper has close, personal connections with colleagues in New York and Colorado with whom she quickly designed a creative proposal for a three-state demonstration project she dubbed “ON BASE.” Operating under New Boundaries for Adverse and Serious Safety Events (ON BASE) proposes to focus on five areas of patient safety: bloodstream infections, wrong-site surgery, retained foreign objects, thrombo-embolic events. Dr. Cooper envisions informing patient expectations through a redesigned informed consent process, decreasing the incidence of the five kinds of adverse events by 10%, implementing disclosure and apology when such events do occur, and mitigating losses in part by moving toward a model that emulates worker’s compensation. RIMS, HARI and the AMA have endorsed ON BASE. The application deadline was January 21, 2010.

MinuteClinic™ moving its headquarters to Woosocket

MinuteClinic, the company that started placing health care kiosks in big box stores, supermarkets and drug stores years ago, was recently acquired by CVS Caremark, the second largest chain of retail-based clinics with about 7,000 outlets in the nation, with more than 7,000 outlets in 43 states.
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Robert Geffner, Ph.D., ABPN, ABPPP, Dawn A. Alley, Ph.D.

INTRODUCTION TO HOSPITAL QUALITY AND SAFETY IMPROVEMENT
David B. Nash, M.D., M.B.A., Richard Jacoby, M.D.

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I am very grateful, by the way, to Dr. Elizabeth Lange, as a practicing pediatrician in our community, and to Dr. Milton Hamolsky, the former Chief of Medicine at Rhode Island Hospital, for sharing some of their thoughts and perspectives on Ed Forman and his career. It is frankly not possible to exaggerate the time giants of Rhode Island medicine.

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I am very grateful, by the way, to Dr. Elizabeth Lange, as a practicing pediatrician in our community, and to Dr. Milton Hamolsky, the former Chief of Medicine at Rhode Island Hospital, for sharing some of their thoughts and perspectives on Ed Forman and his career. It is frankly not possible to exaggerate the time giants of Rhode Island medicine.
Remarks of Dr. Michael E. Migliori upon accepting the Dr. Charles L. Hill Award

I would like to acknowledge my parents, Julius and Gloria. Many of you know my father; he has been practicing anesthesia for the past 47 years. In my third year of medical school, he told me to join the AMA. I asked him why, and he told me because you’re supposed to. Up to this point, being a good kid, if my father told me I was supposed to do something, most of the time I did it. Growing up, that was often all the explanation we would get, or we would need. I joined, figuring it was a bargain for $20 to get JAMA and the Archives of Ophthalmology.

When I got back from residency and my fellowship, I thought I would end up practicing, doing a little teaching, maybe write a few papers. Four months into my practice, Peter DeBlasio calls me and tells me to meet him at the State House, the optometrists want to treat eye diseases. I went because I didn’t want to lose a referral source. Hearing the arguments, I thought all you needed to do was explain to a legislator why something was a bad idea, and that reason and logic would win the day. That was the day I reached maturity.

It became clear that, especially where the General Assembly is concerned, reason and logic have nothing to do with anything. If it did, this state would not be in the state it’s in. There will always be assaults on the practice of medicine, and there will always be a need for vigilance and action to turn back those assaults. And that is when it hit me, that is what my father meant. He said I was supposed to join the AMA, but not because he told me to. I was supposed to support the organizations that represent me, that are the advocates for my patients and me.

I have been extremely fortunate to have been able to actively participate in advocacy at both the local and national levels, and I hope that my efforts have played at least some small part in trying to maintain the honor of medical practice. I have to recognize my family for all they have done, and put up with, along this journey. Missed dinners, travel away from home, phone calls and meetings all take time away from family, and I thank them for their support, patience and understanding.

You have all heard some guy getting up to accept an award, and saying that he could not have done it without his wife, which is usually true, and he usually says that because his wife even wrote his speech. I wrote this speech myself, so I can say it from the bottom of my heart, that my wife Marianne deserves this more than I do. Not only has she had to hold things together while I am jousting with windmills, she has been my best sounding board, critic, and cheerleader, and it is she that you should be giving this award to tonight.

This award is truly an honor for me, to be recognized by your peers is one of the greatest tributes, and for that I am deeply grateful. Dzhelniksoych, Diane.
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EHR Financing Available from Webster Bank

Financial incentives available from Blue Cross, United and through the federal stimulus program have unquestionably been useful in helping some physicians move from paper to electronic record-keeping. However, the cost of implementing Electronic Health Records (EHR) – both in dollars and staff time – still remains daunting for many medical practices, both large and small. The direct cost of making the switch is still conservatively estimated to range from $25,000 to $50,000.

An increasing number of medical practices are nevertheless making the leap, and many more want to do so. While EHRs are not always an unmixed blessing, there is little doubt that a quality EHR, when well-implemented and carefully used, can contribute substantially to improving patient care, reducing overhead in the long run, and creating efficiencies that can enhance the economic viability of a medical practice.

Interestingly in this context, Webster Bank two years ago reached out to the Rhode Island Medical Society to highlight the bank’s interest in building relationships with the medical community by offering advantageous financing to RIMS and its members.

Webster itself has been visibly expanding its presence in Rhode Island, Connecticut, Massachusetts and New York recently and is now the largest independent commercial bank headquartered in New England. The Rhode Island Medical Society now does its banking with Webster.

Of particular interest to Rhode Island physicians is a package Webster designed for RIMS members to help make the switch from paper to EHR more affordable. Features of the package include:

• Check access revolving line of credit (up to $500,000) that can be used to finance EMR hardware, software, training costs and healthcare IT solutions.
• Interest-only payments for one year at competitive rates
• At the end of one year, the outstanding line of credit balance will convert from interest-only to a term loan (up to five years).
• Financing is available for up to 100% of the project cost

More information is available through Webster’s local medical financial services specialist: Joseph P. Lopes, MBA, Vice President 401-421-1548 or email jlopes@websterbank.com.