

# CCFN

CODING & COMPLIANCE FOCUS NEWS

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## Introducing Inside ICD-10: An Announcement from CCFN

It is important for facilities to understand the implications of the October 2013 deadline for implementation of the Internal Classification of Diseases, 10th Revision (ICD-10).

ICD-10 will impact every aspect of the revenue cycle and more. From patient registration to case management and beyond, the ICD-10 code set will affect a variety of departments. The complexity and the scope of ICD-10 is so much more than codes and that is why it is important that staff and providers become knowledgeable about ICD-10.

In addition to latest coding and compliance articles that are published monthly in CCFN, we will provide additional ICD-10 articles each month beginning with this the October issue. Our editorial coverage will include answers to your frequently asked questions, the latest news in ICD-10 and tidbits of information of which you may not be aware. A Word Search puzzle also will be published each month to help you become more familiar with some of the ICD-10 terminology.

Our goal is to provide noteworthy information that will assist in a successful transition into the new world of ICD-10. If you have suggestions for feature ICD-10 articles, please send your suggestion to [compliance2@medassets.com](mailto:compliance2@medassets.com).

We hope you enjoy this addition of CCFN.

### FEATURE ARTICLE



#### **3 Certification for Complexity: Understanding Clinical Laboratory Improvement Amendments**

Clinical Laboratory Improvement Amendments (CLIA) is a program for regulating laboratory testing with the primary objective of ensuring quality laboratory testing, reports Bev Hillinger, RHIA, CPC, in this month's feature article. Administered jointly by the Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), all clinical laboratories must be CLIA-certified to receive Medicare payments, writes Hillinger.

### DOC2DOC

#### **5 ICD-10 Transition: Good News, Bad News for Docs**

On Aug. 22, 2008, the federal government proposed a rule that would require the use of a new coding set — the ICD-10-CM code set — as the standard code set for coding diagnoses on all HIPAA standard transactions, writes Denise Nash. The proposed implementation of the code set will have a profound impact on the operations of physician practices.

### TALKING POINTS

#### **8 The What and Why of General Equivalency Mappings (GEMs)**

Transitioning from ICD-9 to ICD-10 requires conversion or mapping in both clinical and technological forms. To ease the conversion process, The Centers for Medicare & Medicaid Services (CMS) provides GGEMs, explains Darnacea Harris, MHA, RHIT, CCS.

### MODIFIERS CORNER

#### **10 Modifiers Used to Report Items, Services Not Reimbursed by Medicare**

The decision to report a modifier to Medicare that indicates non-coverage and which modifier to report will depend on the modifier's definition, the reason for the non-coverage under the OPPS and the reporting requirements for those non-covered services, explains Sandy Palmer, RHIT.

### INSIDE ICD-10

#### **12 Will the ICD-10 Conversion Cost Me an Arm and a Leg?**

Transitioning to ICD-10 will be a costly undertaking since it will replace an ineffective ICD-9 code set. Other countries switched many years ago. The U.S. healthcare system must be brought current, reports Pamela Pfeifer.

#### **13 Will There Be a Code Freeze for ICD-9 and ICD-10?**

The ICD-9-CM Coordination and Maintenance Committee announced on Sept. 15 2010 that it would implement a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 on Oct. 1, 2013, explains Pamela Pfeifer.

#### **13 Did You Know: Some Commercial Payors Are Not Converting to ICD-10?**

Most commercial payors are not planning to convert immediately to ICD-10, reports Zuriharri Pannell. Instead, she explain, payors plan to use crosswalks, mapping, and internal translation tables, while trying to build a home-grown database that can be utilized with ICD-10 codes mapping back to ICD-9 codes.



# CERTIFICATION FOR COMPLEXITY

## Understanding Clinical Laboratory Improvement Amendments

Clinical Laboratory Improvement Amendments (CLIA) is a program for regulating laboratory testing with the primary objective of ensuring quality laboratory testing. Administered jointly by the Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), all clinical laboratories must be CLIA-certified to receive Medicare payments.

CLIA has three levels of certification, based on the complexity of the laboratory tests performed. Each clinical laboratory test is assigned a complexity level corresponding to the certification level of the laboratory that will perform the test. The three complexity levels are the following:

- Waived, or low complexity
- Moderate complexity, including provider-performed microscopy procedures (PPMP)
- High complexity

### Waived Tests

Waived tests are the simplest and least complex laboratory tests. If a waived test is performed incorrectly, there is no reasonable risk of harm. Blood glucose testing products for the home or office are examples of waived testing products.

Laboratories holding a "Certificate of Waiver" under CLIA may perform only waived tests. As the lowest level of complexity, waived tests may be performed by laboratories holding all types of CLIA certification.

Modifier QW was created to be used by laboratories holding Certificates of Waiver that must append this modifier to the CPT/HCPCS codes for waived tests they perform. Claims for waived tests from these laboratories will be rejected if submitted without the QW modifier. It is important to note that this modifier is not required for waived tests reported by laboratories with higher levels of certification.

Most waived test codes require Modifier QW when reported by Certificate of Waiver facilities; however, certain waived tests do not require this modifier when billed by these laboratories. Urine pregnancy (hCG) testing CPT® code 81025 is a waived test that is not reported with modifier QW by laboratories holding a Certificate of Waiver. Codes for waived tests that are exceptions to use of the QW modifier are listed in the CMS CLIA document "Tests Granted Waived Status Under CLIA."

Another aspect of waived test classifications is the assignment of waived test status to the laboratory test systems (i.e., test kits) used to perform these tests. Manufacturers must apply for classification of their test system products as waived tests.

CMS publishes the latest tests approved by the FDA under CLIA in quarterly transmittals called Change Requests or CRs. The new test systems assigned waived status to be implemented in October are found in transmittal R2244CP (Change Request 7435). Several of the new test systems listed are BTNX Rapid Response Strep A Rapid

Test Strips assigned CPT code 87880QW and Instant Technologies, iCup DX Drugs Screen Cup with HCPCS code G0434QW.

### Moderate Complexity/PPMP

This small group of codes includes mainly provider-performed microscopy procedures, or PPMP. The tests are generally performed in physician office laboratories, or they are needed for immediate patient care. A urine microscopic exam reported with CPT code 81015 is classified as a PPMP test.

Laboratories holding a Certificate of PPMP may also perform waived tests. Modifier QW is not needed when these facilities report waived tests.

### High Complexity

All other clinical laboratory tests not classified at one of the two lower levels are considered high complexity. As the most complex tests, high complexity tests often require multiple steps and are not automated. Training is required to perform these tests and to interpret the results, and the risk of erroneous results is substantial. Included in this level are tests requiring sample processing, which is blood-based testing requiring centrifugation of whole blood to serum or plasma.

A CLIA Certificate of Registration, Compliance or Accreditation is required for a laboratory to perform high complexity testing. This level of certification is generally held by hospital laboratories and reference laboratories.

A Certificate of Registration is the initial certificate provided to a laboratory seeking CLIA compliance status. It is valid for no more than two years or until an inspection can be conducted. Once an inspection has demonstrated compliance, a Certificate of Compliance is issued.

Another option is to seek certification from a non-CMS accreditation agency. CMS has deemed certain agencies to have requirements to be equal to, or more stringent than, CLIA. A Certificate of Accreditation obtained from one of these agencies is also a high level certification. A few of the agencies that can provide accreditation include The Joint Commission, American Osteopathic Association and College of American Pathologists. Further information on this option is available on the CMS CLIA website, listed in the Resources at the end of this article.

#### Drug Screen Testing Codes G0431 and G0434

Recent changes to the qualitative drug screen testing HCPCS codes G0431 and G0434 have brought to the forefront the need to understand CLIA complexity levels. The descriptions for these codes now include the CLIA complexity level, with G0431 describing a high complexity testing method of qualitative drug screening, while G0434 describes both waived and moderate complexity testing.

**G0434QW Drug screen**, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter

**G0431 Drug screen**, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter

G0434 is an example of a code that can be used for reporting tests with different levels of complexity, both waived and moderate. Laboratories holding a Certificate of Waiver may perform waived drug screens and report G0434QW. Laboratories with Certificates of PPMP, Registration, Compliance or Accreditation may perform moderate complexity drug screens and report G0434.

#### Analytes with Different Complexity Levels

Some CPT/HCPCS codes can be assigned to more than one complexity classification. This occurs when more than one code describes a substance, or analyte, that is undergoing testing. One type of analyte can have multiple testing methods with varying levels of complexity such as Lyme disease. A confirmatory test for Lyme disease, reported with CPT code 86617, requires the highest level of certification, while the Lyme disease antibody test code 86618 holds waived status and may be reported by laboratories with all levels of certification.

#### Examples

Below are examples of CPT/HCPCS codes assigned to the three CLIA levels of complexity. Also listed are examples of test system products assigned to the waived test codes.

#### Waived Tests

- 82947QW Glucose; quantitative, blood (except reagent strip)
  - HemoCue B-Glucose Photometer
- 81025 Urine pregnancy test, by visual color comparison methods
  - Note 81025 does not require modifier QW when reported by Certificate of Waiver laboratories
- 87880QW Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A
  - BTNX Rapid Response Strep A Rapid Test Strips
- G0434QW Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
  - Instant Technologies, iCup DX Drugs Screen Cup
- 86618QW Antibody; Borrelia burgdorferi (Lyme disease)
  - Wampole PreVue<sup>®</sup> B. burgdorferi Antibody Detection Assay

#### Moderate Complexity/PPMP

- Q0114 Fern test
- 81015 Urinalysis; microscopic only

#### High Complexity

- G0431 Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
- 86617 Lyme disease confirmatory (Western blot immunoblot)
- 86320 Serum immunoelectrophoresis

#### CMS CLIA Documents

CMS publishes updates to CLIA tests in transmittals. As mentioned earlier, quarterly updates of new waived tests are provided in this manner. An ongoing listing of Tests Granted Waived Status Under CLIA is generally attached to this transmittal.

Also published in transmittals are annual and occasional as needed updates of CLIA status for new, revised and deleted CPT/HCPCS codes. These codes are classified as either Subject To or Excluded From CLIA edits. The latest transmittal, R915OTN, contains additional HCPCS codes subject to CLIA edits effective Jan. 1, 2011.

The CMS CLIA website includes complete lists of the waived and PPMP tests and those Subject To or Excluded From CLIA edits.

#### About the Author

Bev Hillinger, RHIA, CPC, is a Senior Coding and CDM Analyst for MedAssets. She has 27 years of experience in the healthcare industry in software and Health Information Management (HIM) settings. During her ten years with MedAssets, she has worked with hospital outpatient data content and product development. She has expertise in the Outpatient Prospective Payment System (OPPS) and revenue cycle management. Ms. Hillinger serves on a local college HIM program advisory board and the ICD-10 planning group for the Washington State Health Information Management Association (WSHIMA).

#### RESOURCES

Transmittals, R2244CP (CR 7435), [www.cms.gov/transmittals/downloads/R2244CP.pdf](http://www.cms.gov/transmittals/downloads/R2244CP.pdf)

R915OTN (CR 7513), [www.cms.gov/transmittals/downloads/R915OTN.pdf](http://www.cms.gov/transmittals/downloads/R915OTN.pdf)

CMS CLIA website, [www.cms.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp#TopOfPage](http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage)



## ICD-10 Transition: Good News, Bad News for Docs

I have some good news and some bad news, sounds like the start of a bad joke but this is no joke.

On Aug. 22, 2008, the federal government proposed a rule that would require the use of a new coding set – the ICD-10-CM code set – as the standard code set for coding diagnoses on all HIPAA standard transactions. An update of the ICD-9-CM code set, the proposed rule expands diagnosis codes by a factor of five, enabling greater specificity in the coding of diagnoses, while allowing for expansion in future years, and, overall, improving the description of current technologies.

The proposed implementation of the code set would have a profound impact on the operations of physician practices. The Centers for Medicare & Medicaid Services (CMS) is adamant that ICD-10 is coming and the implementation date is scheduled for commencement on Oct. 1, 2013. This means that you will be assigning your last ICD-9 code on Sept. 30, 2013. The bad news is that as of October 1 you or someone in your office will begin assignment of diagnosis using ICD-10-CM. The good news: for services delivered in any setting you will continue to code using Current Procedural Terminology® (CPT) and the Healthcare Procedural Coding System (HCPCS) for assignment of procedures. Therefore, your office will not have to learn how to code using ICD-10-PCS.

So what is this ICD-10 anyway?

The ICD-10-CM codes are significantly more detailed and granular, requiring more documentation to support medical necessity.

### Longer Alphanumeric Codes

All ICD-10-CM codes are alphanumeric, not just the supplementary classifications (V codes) and causes of injury (E codes) that are found in the ICD-9-CM system. In addition, ICD-10-CM codes can be up to seven characters in length, rather than the previous limit of five.

### More Codes, More Specificity

The number of codes increases from about 13,600 to 69,000. However, physicians will not use them all. Most physicians use a relatively small number of diagnosis codes related most closely to their specialty.

Nonspecific codes are available in ICD-10-CM, as they are in ICD-9-CM. This will allow assignment of codes even when specific documentation is unavailable. However, detailed documentation will allow physician practices to take full advantage of the information that can be conveyed by the new, detailed codes.

The increased specificity in ICD-10-CM means that codes are easier to assign correctly, because there are fewer ambiguities. This should result in fewer coding errors and fewer unpaid claims and non-coverage

issues. The specificity of the codes should decrease the requests for submission of additional supporting documents on many claims.

### Organization and Categorization of Diseases Changes

ICD-10-CM is structured differently. In addition to the longer, alphanumeric code structure, it describes diseases differently.

For example: Hypertension is no longer split between benign and malignant. It has one code, I10, which describes essential (primary) hypertension and includes the diagnostic statement of high blood pressure.

R00 through R99, Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, replaces the current 780–789 codes in ICD-9-CM. This new category has been expanded to include hundreds of codes. For example, abdominal pain will now be coded differently from acute abdomen, abdominal tenderness, and colic, which were all previously described with category 789.0x.

In the category for osteoarthritis, ICD-10-CM codes M19.01–M19.93, unspecified locations, are no longer grouped with the specific locations for each type (the familiar .9 code in most ICD-9-CM categories). They are now found at the end of the code grouping (M19.90–M19.93) for each specific type, but in an unspecified location.

In addition, traumatic osteoarthritis is now more appropriately indexed and described as posttraumatic osteoarthritis, the true condition.

One of the good fallouts of the implementation of ICD-10-CM is one code, not two, for many complex conditions.

For example, diabetes mellitus codes are expanded to include the classification of the diabetes and the manifestation. The category for diabetes mellitus has been updated to reflect the current clinical classification of diabetes and is no longer classified as controlled/uncontrolled:

- E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
- E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
- E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
- E11.41, Type 2 diabetes mellitus with diabetic mononeuropathy \*

\*ICD-10-CM Primer, [www.ahima.org](http://www.ahima.org)

This should simplify capturing the correct code and will aid in capturing the patient's correct severity of illness.

### Documentation

ICD-10-CM offers a new granularity to the coding process and this will require additional documentation to support a patient's treatment plan. This could lead to considerable changes in the business process of a practice, as the extent and amount of clinical documentation would significantly change based on the greater specificity of coding.

In ICD-9-CM, the correct code for coma is 780.01, with no additional specificity. ICD-10-CM has expanded the codes for coma. Current documentation does not always give us this detail in the medical record. In ICD-10-CM coma must be coded based on a coma scale.

In a physician practice, when coding for a neurosurgeon, for example, the coder may know the patient is in a coma with a skull fracture. However, the documentation won't

indicate how the patient arrived to meet the 7th character requirement. Also we currently do not code based on the coma scale, so documentation will be challenging with ICD-10-CM.

R40.2 Coma  
Coma NOS  
Unconsciousness NOS  
Code first any associated:  
coma in fracture of skull (S02.-)  
coma in intracranial injury (S06.-)

The following 7th character extensions are to be added to codes R40.21, R40.22, R40.23

1 in the field [EMT or ambulance]  
2 at arrival to emergency department  
3 at hospital admission  
4 24 hours after hospital admission  
9 unspecified time

A code from each subcategory is required to complete the coma scale

R40.2.....Coma (continued)  
R40.20.....Unspecified coma  
R40.21.....Coma scale, eyes open  
R40.211....Coma scale, eyes open, never  
R40.212...Coma scale, eyes open, to pain  
R40.213...Coma scale, eyes open, to sound  
R40.214...Coma scale, eyes open, spontaneous

Note: These codes are intended primarily for trauma registry and research but may be utilized by all users of the classification who wish to collect this information.

R40.22.....Coma scale, best verbal response  
R40.221...Coma scale, best verbal response, none  
R40.222...Coma scale, best verbal response, incomprehensible words  
R40.223...Coma scale, best verbal response, inappropriate words  
R40.224...Coma scale, best verbal response, confused conversation  
R40.225...Coma scale, best verbal response, oriented

R40.23.....Coma scale, best motor response  
R40.231...Coma scale, best motor response, none  
R40.232...Coma scale, best motor response, extension  
R40.233...Coma scale, best motor response, abnormal  
R40.234...Coma scale, best motor response, flexion withdrawal  
R40.235...Coma scale, best motor response, localizes pain  
R40.236...Coma scale, best motor response, obeys commands

Jeffrey B. Miller, Esq., and Alice Anne Andress, in their article, "Procedures to Improve Your Claims," appearing in *Physicians News Digest*, October 2002, write, "For documentations supporting diagnoses or procedures, physicians first must ensure that the services provided are consistent with the symptoms of the patient and that they satisfy generally accepted medical standards. Thereafter, physicians must ensure that their documentation is adequate for coding and quality assurance purposes. Part of this effort requires that physicians understand and remain current on the relevant documentation standards. Physicians should strongly consider attending coding and documentation workshops on an annual basis to establish and to refresh their skills in documentation, and to master changing requirements."

Are we having fun yet?

Remember that the new rule is not a simple substitution of one code set for another. Your practice should not rush off to train the entire coding staff; it is too early for that. Coding staff can begin training in the actual use of ICD-10-CM and the associated guidelines in 2013 - a time frame of six to nine months prior to October 1 will be best for hands-on training. You should avoid having your practice coders train with hospital coders, because the areas of concentration will be entirely different for the two groups. Your practice coders should be trained in groups from a similar specialty, if possible, and with training materials customized for the physician practice environment.

However, it is a good time to assess each coder's current level of anatomy and physiology knowledge, because ICD-10-CM could require more than they may have needed previously. If coders will use new technology to help with ICD-10-CM code assignment, this would also be a good time to inventory their computer skills. The time between now and the end of 2012 can be used to implement a skills development program for areas such as anatomy and physiology, disease pathology or pharmacology, and enhancement of computer skills that might be needed as new systems are implemented and provide general information now about the upcoming changes and what to expect. Keep the staff informed about what the plans are.

#### What should have happened at your practice by now?

- Identification and appointment of a physician champion
- Downloaded and read AHIMA's "ICD-10 Preparation Checklist" ([www.ahima.org/ICD10](http://www.ahima.org/ICD10))
- Identification and appointment of an ICD-9-CM/ICD-10-CM content expert
- Identification and appointment of a project leader
- Interdisciplinary steering committee established
- Informed all physicians of upcoming changes and the practice's implementation plans
- Informed all staff of upcoming changes and the implementation plans
- Assess skill levels of staff for future needs
- Assess documentation improvement needs

#### 2011-2012

- Provide periodic updates on the implementation's progress
- Implement any necessary skill development or enhancement programs for staff and physicians
- Continue to work through implementation plans

#### 2013

- Provide hands-on training for staff using materials designed for physician practices
- Complete implementation plans and prepare for go-live on October 1

#### Implementation Cost

According to a study conducted by Nachimson Advisors, LLC the cost to practices detailed below could be substantial. (see table one below)

Also, according to the study, the move to the ICD-10-CM will increase documentation activities about 15 to 20 percent. This translates into a permanent increase of 3 percent to 4 percent of physician time spent on documentation for ICD-10-CM. Translation, if you had any free time prior to implementation, you won't after.

**Cash Flow Disruption.** With a change to ICD-10-CM, it is expected that health plan payment amounts will be changing based on severity of diagnosis and changes in coverage. Significant changes in reimbursement patterns will disrupt provider cash flow for a considerable period of time. Nachimson Advisors estimated the range from \$19,500 for a typical small practice to \$650,000 for a typical large practice.

All practices would be impacted by the changing of diagnosis codes. Those clinicians who do not participate in any insurance transactions will still need to understand how to document and assign ICD-10-CM codes, as public health reporting or exchanging information with other practices may require the use of this newer code set.

In closing please remember that Medicare fully anticipates being ready for the Oct. 1, 2013 compliance deadline. Much like the countdown to Christmas this deadline is only about 700 days away. However, at the end of the wait you are not receiving presents from Santa as non-compliance will be met with denials and most important decreased cash flow.

#### About the Author

Denise M. Nash, MD, CCS, CIM, is the medical director and product owner for the Bundled Payments solution for MedAssets. Denise has more than 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise also has worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals and insurance plans and has worked for the Office of the Inspector General (OIG) of New Hampshire in its Fraud and Abuse Division.

<b>TABLE ONE</b>	<b>TYPICAL SMALL PRACTICE</b>	<b>TYPICAL MEDIUM PRACTICE</b>	<b>TYPICAL LARGE PRACTICE</b>
<b>EDUCATION</b>	\$2,405	\$4,745	\$46,280
<b>PROCESS ANALYSIS</b>	\$6,900	\$12,000	\$48,000
<b>CHANGES TO SUPERBILLS</b>	\$2,985	\$9,950	\$99,500
<b>IT COSTS</b>	\$7,500	\$15,000	\$100,000
<b>INCREASED DOCUMENTATION COSTS</b>	\$44,000	\$178,500	\$1,785,000
<b>CASH FLOW DISRUPTION</b>	\$19,500	\$65,000	\$650,000
<b>TOTAL</b>	<b>\$83,290</b>	<b>\$285,195</b>	<b>\$2,728,780</b>



## The What and Why of General Equivalency Mappings (GEMs)

Since the ICD-10 code sets are a significant variation from ICD-9 systems, transitioning from the old to the new system requires conversion or mapping in both clinical and technological forms. And that makes Map an important component in the ICD10 conversion process. To ease the conversion process, The Centers for Medicare & Medicaid Services (CMS) provides General Equivalency Mappings (GEMs).

GEMs is a detailed, bi-directional translation dictionary that can be used to translate large amounts of data from one code set to another. GEMs are bi-directional because they provide translation forward from ICD-9-CM to ICD-10-CM/PCS codes and backward mapping from ICD-10-CM/PCS codes to ICD-9 codes. The purpose of the GEMs is “to create a useful, practical, code to code translation reference dictionary for both code sets, and to offer acceptable translation alternatives whenever possible,” according to CMS. Developed by the Centers for Disease Control and Prevention, GEMs support all uses of healthcare data as a starting point for translation alternatives.

In addition to providing a means for data translation, GEMs are also used in the following ways:

- Ensure consistency in national data reporting
- Assist in the conversion of multiple databases including:

- Payment systems
- Payment and coverage edits
- Risk adjustment logic
- Quality measures
- Disease Management programs
- Financial modeling
- Research application involving trend data
- Migrate ICD-9 historical data to ICD-10 based on analysis
- Create test records for system upgrades
- General reference

### The Proper Usage of GEMS

When using GEMs, it is important to understand that the phrases useful and practical, and whenever possible in the GEMS definitions have distinct emphasis. GEMs are not a simple crosswalk from ICD-9 to ICD-10. Rather, GEMs are intended to offer a compromise interpretation whether the intent is to track newly coded data, or to translate existing coded data to the new equivalent. GEMs provide all sectors of the industry a common starting point from which to convert codes between the systems, or to create bi-directional applied mappings. The translations are based on the meaning of the code as contained in the tabular instructions, index entries, official coding guidelines, and applicable Coding Clinic for ICD-9-CM advice. Since GEMs were not developed with reference to Medicare data, they extend equally to all types of users. Each classification system offers technical guidelines for use when mappings are not straightforward.

GEMs were intended to be used when there is no access to the detail found in the original medical record. Hospitals and organizations with access to the medical record should use the documentation in the medical record to compare against code assignments for accuracy in individual medical records. CMS recommends Coders use only ICD-10-CM/PCS code books and encoders when coding individual records. As the Coder has access to more specific data, the codes assigned using this method will be more specific than code translations found in the GEMs. Remember, GEMs are most effective in electronic conversions when:

- Translating lists of codes, code tables, or other coded data
- Converting a system or application containing ICD-9 codes
- Creating a one-to-one crosswalk between code sets to translate records or other coded data
- Studying the differences in mapping the classification systems

Maps between ICD-9-CM and ICD-10-CM/PCS are an attempt to express relationships between the code sets that are more or less equivalent, insofar as this is possible. The correlation between ICD-10-CM and ICD-9-CM share the same conventions of organization and formatting making translation straightforward. For ICD-10-CM diagnosis mapping, GEMs guidance

offers an acceptable translation for source system code sets, however alternatives exist that are more specific than the source system and these alternatives should be used when better alternatives are not available. This technical guidance can be found in the General Equivalence Mappings Documentation for Technical Users on the CMS/ICD10 website [www.cms.gov/icd10](http://www.cms.gov/icd10).

ICD-9-CM and ICD-10-PCS are so different that a map between the two code sets only offers possible compromises rather than an exact code-to-code crosswalk.

ICD-10-PCS offers a whole new set of GEMs guidance. Because PCS coding is so much more specific than ICD-9-CM procedure codes, one ICD-9 code may be mapped to a large number of ICD-10-PCS codes, and one ICD-10-PCS code can be mapped to several ICD-9 codes. For example see table one and two.

In the example, we see that one PCS code can encompass more than one ICD-9 code in a given procedure. Oftentimes, in PCS translation, there is no one clear choice. This is one of the reasons the GEMs should not be used as the sole source of translation in data conversions. Remember, there is no simple crosswalk from ICD-9-CM to ICD-10-CM/PCS. The intent of the GEMs is to organize the code differences and offer valid alternatives in a meaningful way. Therefore, the GEMs are not appropriate for every type of data conversion project. Small conversion projects may be completed more efficiently using the ICD-10-CM/PC code books or encoders.

## The Five Principles of GEMS

- 1. Complete code definition** is the complete meaning of a code taken into account?
- 2. Mapping rules** is the code in the source system (the code set being mapped from), mapped to the appropriate target system (the code set being mapped to) code?
- 3. Mapping specificity** is the level of detail in the source system code adequate for assignment to the target system code.
- 4. ICD-10-CM/PCS detail** are decisions to reduce coding detail in a specific code applicable?
- 5. ICD-10-CM/PCS improvements** is the classification between the two code sets compatible?

In order to gain the optimum use of GEMs, users must caution against evaluating systems based on strict translations found in ICD-10-CM/PCS. It is important to understand the need to reconcile linked codes, and appropriately evaluate the methods used to reconcile these differences. As the scope of these differences varies, users will need to ensure the differences are not overlooked so that quality mapping can occur.

Flawed linking decisions can lead to data distortion, misinterpretation and inaccuracies resulting in challenged data trending, reporting, tracking, and audit results.

## About the Author

Darnacea Harris MHA, RHIT, CCS, is an AHIMA Approved ICD-10-CM/PCS Trainer with more than 20 years experience in the coding, compliance and reimbursement industry. Darnacea has previously held such positions CCA Rules Manager, Assistant Director HIM, HIM Manager, Coding Manager, and Consultant. She has also held teaching positions at several colleges and universities where she taught coding, billing, HIM, and supporting courses.

## REFERENCES

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Centers for Medicare and Medicaid Services, ICD-10, [www.com.hhs.gov/ICD10](http://www.com.hhs.gov/ICD10)

Centers for Medicare and Medicaid Services, ICD-10-PCS 2010 Code Tables and Index 2010 ICD-10-PCS and GEMs ICD-10

[www.cms.gov/ICD10/11b1\\_2011\\_ICD10CM\\_and\\_GEMs.asp#TopOfPage](http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage)

[www.cms.gov/ICD10/11b\\_2011\\_ICD10PCS.asp#TopOfPage](http://www.cms.gov/ICD10/11b_2011_ICD10PCS.asp#TopOfPage)

Federal Register/Vol 74, No. 11 (2009). HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS. [edocket.access.gpo.gov/2009/pdf/E9-743.pdf](http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf)

ICD-10-PCS The Complete Draft Code Set, (2010) Ingenix,: UT

**TABLE ONE**  
ICD-9 to ICD-10-PCS

ICD-9- Code	Description	ICD-10-PCS Code	Description
02.11	Simple suture of Dura mater of brain	00Q20ZZ	Repair of Dura mater, open approach
02.11	Simple suture of Dura mater of brain	00Q23ZZ	Repair of Dura mater, percutaneous approach
02.11	Simple suture of Dura mater of brain	00Q24ZZ	Repair of Dura mater, percutaneous endoscopic approach

**TABLE TWO**  
ICD-10-PCS to ICD-9

ICD-10-PCS Code	Description	ICD-10-PCS Code	Description
02713DZ	Dilation of coronary artery, two sites using intraluminal device, percutaneous approach	00.66 AND	PTCA or coronary Atherectomy
		00.41 AND	Procedure on two vessels
		36.06	Insertion of non-drug-eluting coronary stents

## Modifiers Used to Report Items, Services Not Reimbursed by Medicare

There are many different medical items and services that are not reimbursed by Medicare under the Outpatient Prospective Payment System (OPPS). Moreover, there are various reasons why these items and services are not paid. There are also times when these non-covered items and services need to be reported on a Medicare OPPS claim.

The decision to report a modifier to Medicare that indicates non-coverage and which modifier to report will depend on (1) the modifier's definition, (2) the reason for the non-coverage under the OPPS and (3) the reporting requirements for those non-covered services.

Providers and facilities billing Medicare need to be cautious when providing non-covered items and services. Medicare warns us that billing non-covered items without the appropriate use modifiers and Advanced Beneficiary Notices (ABNs) could be considered fraud and abuse of the system.

### Modifiers Used When Reporting Non-covered Items

The appropriate use of the following HCPCS modifiers is necessary when reporting non-covered items and services to Medicare. Medicare contractors use the modifiers to determine who is liable for the non-covered charges — the provider or the beneficiary.

**GA** – Waiver of liability statement issued as required by payor policy, individual case

**GY** – Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for Non-Medicare insurers, is not a contract benefit

**GX** – Notice of Liability Issued, Voluntary Under Payor Policy

**GZ** – Item or service expected to be denied as not reasonable and necessary

Since the 2010 re-activation of Modifier GX for voluntary ABNs, the description and guidance for using Modifier GA had to be revised. The previous description of Modifier GA was the following: Waiver of liability statement on file.

### Reasons for Non-coverage Under OPPS

The Medicare Program Integrity Manual defines a non-covered service as one for which there is not a benefit category, a service that is statutorily excluded or a service that is not reasonable and necessary under the Social Security Act. Title XVIII of the Social Security Act is administered by The Centers for Medicare & Medicaid Services (CMS) and is the primary authority for all Medicare coverage provisions and subsequent policies. Benefits not addressed in Title XVIII of the Act are considered "statutorily excluded." This means that Medicare is not authorized to pay for them. Further details of the specific reasons for Medicare non-coverage where Modifiers

GA, GY, GX and GZ may be used include the following:

- **No Medicare benefit category for the service/procedure**  
This includes items that are not listed in a benefit category for outpatient services paid under Medicare Part A or Part B, Title XVII of the Social Security Act.
- **Services that are statutorily excluded**  
The current Integrated Outpatient Code Editor (I/OCE) files include lists of items and services that are statutorily excluded. Medicare provides examples of statutorily excluded services to beneficiaries in the "Medicare and You" handbook. These include the following:
  - Long-term care
  - Routine dental care
  - Dentures
  - Cosmetic surgery
  - Acupuncture
  - Hearing aids
  - Exams for fitting hearing aids

The codes for the items that are either statutorily excluded or are not included in a Medicare benefit category are listed with status indicator "E" in the I/OCE files and in the current OPPS Addendum B.

- **Not medically reasonable and/or necessary under Medicare**

- Medicare is required by statute to pay for services that meet medical necessity. This is defined as services and items found to be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Items that do not meet the definition of medically reasonable and/or necessary are non-covered by Medicare.

- Medicare has two types of coverage policies: National Coverage Decisions (NCDs) and Local Coverage Determinations (LCDs). The Centers for Medicare & Medicaid Services (CMS) develop NCDs while Medicare contractors have the authority to develop LCDs. Effective Dec. 7, 2003, contractors issued LCDs instead of LMRPs (local medical review policies)

**Example:** An item that may be non-covered as specifically described in the CMS National Coverage Determinations Manual:

NCD 50.3 - Cochlear Implantation. Cochlear implantation may be covered based on Nationally Covered Indications as listed in the NCD Manual. When the beneficiary circumstances do not meet those indications the procedure would be considered non-covered since it would not meet the medical necessity requirements of the cochlear implantation procedure.

- Items and Services can also be non-covered due to time, frequency or quantity limits

- These limitations include services such as:
  - Screening tests for cancer: Prostate, Colorectal, Breast
  - Screening tests for Cardiovascular disease, Diabetes, Abdominal Aortic Aneurysm (AAA)
  - Preventive Exams
  - Immunizations

**Example:** An item that may be non-covered due to time is HCPCS code G0402 - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the

first 12 months of Medicare enrollment. If an IPPE examination was reported after the first 12 months following the beneficiary's enrollment it would not be a valid Medicare benefit. Additionally, since the IPPE is a once in a lifetime benefit, more than one occurrence would not be paid as well.

### 3 – Reporting requirements for non-covered services

Medicare includes guidance and requirements for reporting non-covered services in Chapter 1 of the Medicare Claims Processing Manual. Section 60, "Provider Billing of Non-covered Charges on Institutional Claims," lists three different basic payment conditions related to non-covered charges in table 1 of subsection 60.1.1. Only one of the conditions below can apply to a given line item of a claim.

#### Payment Condition 1

Items and services being billed are statutorily excluded from Original Medicare coverage, meaning it is not defined as a specific Medicare benefit defined in the Act; therefore, it is never paid

#### Payment Condition 2

Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider

#### Payment Condition 3

Items or service is presumed to be a Medicare benefit and can be paid

#### Summary

This article is an introduction as to the reasons that modifiers for non-covered items and services would be required and the importance of using one of the modifiers when they are reported. We will provide individual guidance related to using modifiers GA, GY, GX and GZ in future CCFN Modifier Corner articles.

#### About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective

Payment System (OPPS). She has more than 14 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management.

#### REFERENCES

Medicare 100-04 Claims Processing Manual, Chapter 1, [www.cms.gov/manuals/downloads/clm104c01.pdf](http://www.cms.gov/manuals/downloads/clm104c01.pdf)

Medicare 100-08 Program Integrity Manual I Exhibits I Definitions, [www.cms.gov/manuals/downloads/pim83exhibits.pdf](http://www.cms.gov/manuals/downloads/pim83exhibits.pdf)

ADDENDUM D1.—FINAL OPPS PAYMENT STATUS INDICATORS FOR CY 2011, [www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS\\_1504\\_FC\\_addenda.zip](http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS_1504_FC_addenda.zip)

Social Security Laws, Title XVIII—Health Insurance For The Aged And Disabled, [www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm)



## INSIDE ICD-10

## Will the ICD-10 Conversion Cost Me an Arm and a Leg?

By Pamela Pfeifer

The transition to ICD-10 in the United States is long overdue. It will be a costly and huge undertaking since ICD-10 will replace a very out-dated, ineffective ICD-9 code set. Most other countries have made the switch many years ago. The United States healthcare system must be brought current.

The good news is that ICD-10 coding will allow for better patient care, trending, and better patient outcomes, but all these changes do not come cheaply.

According to RAND Science and Technology Policy Institute, the estimated conversion is from \$425 million to \$1.5 billion in one-time costs, plus \$5 million to \$40 million in annual lost productivity. Healthcare providers will incur costs for computer programming, and the needed training of medical personnel to include coders and physicians. Productivity of coders and physicians will decrease as they learn the new coding of ICD-10 and it is estimated that it could take up to three years for productivity to return to normal levels.

Many healthcare providers assume that their vendors will take care of everything for them. This is not true and the vendors are only a small piece of the puzzle. While vendors must have their products ready for the conversion, the bigger pieces are the "in-house" customizations that organizations have been using. These customizations are frequently found in applications such as code scrubbing software, dictionaries, claim form logic, and reporting tools. Therefore, you, as a provider, must examine every place in which your organization currently

uses an ICD-9 code and assume it will soon use, instead, the ICD-10 code.

So, take a "walk" through the complete cycle of the data — from the moment the patient encounter starts until final payment is received. During this walk you should determine who and what steps are provided by vendors and, then determine what steps are accomplished "in-house." This assessment is a good place for the project team to begin and this can drive the success of your conversion.

The process of identifying, testing and changing systems to accommodate the ICD-10 conversion will be more costly to those providers that have more home-grown systems and more customizations than others. Remember not all processes are electronic, so be sure to also review all your processes that still use paper. You are responsible to modify all data fields that have been identified as originating from an "in-house" or "internal" source and your vendors can assist you with all the others.

There are vendor tools available to assist all healthcare providers and payors with the transition. Any purchase of software should include the due diligence with regard to the handling of ICD-10. There are tools available to crosswalk ICD-9 to ICD-10 and some that can develop rules and produce scenarios to assist the providers and payors in determining the financial impact of reimbursement on coding changes. All reimbursement schemes based on ICD-9 diagnosis or inpatient procedure codes will be impacted by the conversion to ICD-10.

No matter what, the transition will cost you money, but you can be prepared for it and have a budget for it. Healthcare providers should communicate internally and with their external clinical partners to reduce the chance of delayed revenue and payment denials. The coordination of the effort and the testing will be the most resource and time consuming portion of the transition. Clear communication and early preparation are keys to a successful implementation.

**REMEMBER:** The transition to the new code set will take place on Oct. 1, 2013. If you are not ready for the transition by this date, your organization will be at risk for a revenue shutdown coupled with a loss of cash flow and the possibility of penalties due to payors' readiness failure.

Your assessments should already be underway, are yours?

### About the Author

Pamela Pfeifer is a charge and revenue analyst and is a member of the Integrity Services team that supports ICD-10 at MedAssets. As a healthcare professional, Pam has over 30 years of experience. In her previous roles she has held positions in IT clinical management, hospital laboratory, inpatient clinical care areas, physician office administration, coding, billing, collections and reimbursements.

### RESOURCES

[www.cms.hhs.gov/ICD10](http://www.cms.hhs.gov/ICD10)

[www.icd10watch.com](http://www.icd10watch.com)

[www.ahima.org/icd10](http://www.ahima.org/icd10)

## Will There Be a Code Freeze for ICD-9 and ICD-10?

By Pamela Pfeifer

The ICD-9-CM Coordination and Maintenance Committee announced on Sept. 15 2010 that it would implement a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 on Oct. 1, 2013.

The partial freeze will follow this schedule:

- **Oct. 1, 2011** – The last regular updates to both ICD-9 and ICD-10 code sets will be made.
- **Oct. 1, 2012** – There will be ONLY limited updates to both ICD-9 and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- **Oct. 1, 2013** – There will be limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. There will be no updates to ICD-9-CM, it will no longer be used for reporting as of this date.
- **Oct. 1, 2014** – Regular updates to ICD-10 will begin.

The committee will continue to meet twice a year during the partial freeze. At the meetings the public will be actively involved and asked to comment on whether the requests for the new diagnosis and procedure codes should be created based on the criteria for the capture of new technology and/or diseases. The code requests that do not meet the criteria will then be evaluated for implementation on or after Oct. 1, 2014 when the partial freeze has ended.

### REFERENCES

[www.cms.gov/ICD10/Downloads/Partial\\_Code\\_Freeze](http://www.cms.gov/ICD10/Downloads/Partial_Code_Freeze)

[journal.ahima.org/2010/09/15/code-freeze-coming-for-icd-9-and-10](http://journal.ahima.org/2010/09/15/code-freeze-coming-for-icd-9-and-10)

## Did You Know: Some Commercial Payors Are Not Converting to ICD-10?

By Zuriharri Pannell

Most commercial payors are not planning to convert immediately to ICD-10; instead they plan to use crosswalks, mapping, and internal translation tables, while they try to build a home-grown database that can be utilized with ICD-10 codes mapping back to ICD-9 codes.

Payors are not required to convert to ICD-10-CM/PCS. Instead, they are only required to be ANSI X12 Version 5010 compliance ready by Jan. 1, 2012. Although this allows payors to avoid expensive reprogramming of all their payment systems, it creates opportunity for confusion and claim processing errors. This would be chaotic for providers when looking at claim processing and reimbursement electronically.

Some providers have already expressed concerns about the possible problems should payor not implement ICD-10 into their systems — problems such as payment delays, claim denials, and additional documentation review. Based on healthcare industry specters, this could lead to potential mischief and intentional denials should payors take this approach. That's because payors' translation tables could be inappropriately mapped to incorrect codes in both ICD-9 and ICD-10.

Example 1: Assuming Oct. 1, 2013 is here, provider (XYZ acute hospital) sends its electronic claim using F458 (other somatoform disorders) ICD-10-CM code to payor (I Stand Alone Health Insurance) that receives the claim and translates the ICD-10 code to its ICD-9-CM 306.3(Physiological malfunction arising from mental factors; skin), because the payor has used backwards mapping. The payor figures that the code is correct because it is basing the claim on the frequency use of that code, assuming this payor paid 5 million claims in 2012 with ICD-9-CM 306.3(Physiological malfunction arising from mental factors; skin), which would be incorrect in 2013 based on clinical documentation. ICD-10 would allow the code to be coded to the greatest specificity which would either give a higher reimburse-

ment or a lower reimbursement. Therefore this encounter would cause a delay in payment or claim denial pending additional documentation.

Example 2: Assuming Oct. 1, 2013 is here, the provider's (XYZ acute hospital) preauthorization specialist makes a call to payor (I Stand Alone Health Insurance) to obtain a precertification number for ICD-10-PCS O5PC3JZ (Removal of Synthetic Substitute from Right Knee Joint, Percutaneous Approach), but when the payor mapped the ICD-10-PCS back to ICD-9-CM procedure code, 00.80 (Revision of knee replacement, total (all components)), the code did not specify clearly the approach that was used in determining the code for ICD-10-PCS.

As evidenced by the above scenarios, the decision that payors are proposing — the use home-grown database that can be utilized with ICD-10 codes mapping back to ICD-9 codes — will most likely create confusion and the delay of reimbursement to providers.

According to an analysis posted by The Centers for Medicare & Medicaid Services (CMS) on its website healthcare payors that were using ICD-10 data back to ICD-9 caused patients to be reassigned to lower paying MS-DRGs in an inpatient setting. According to the CMS website, the ICD-10 to ICD-9-CM code maps were selected based on inpatient code frequency data, but five percent of the mappings occurred when there were multiple ICD-9-CM map alternatives. These were not necessarily mapped correctly in means of the terms in ICD-10-CM due to specificity. In contrast, four percent of mappings were also inconsistent because there were multiple ICD-9-CM procedure map alternatives and clusters. The decrease in payment due to incorrect mapping is across the top 10 percent of inpatient hospitals, according to information on the CMS website. Consequently, the use of the Reimbursement Map could be

[...Continued on page 15](#)

## Coding and Compliance Webinars from MedAssets

If you were unable to attend any of the previously presented Coding and Compliance Webinars, it is not too late to gain important knowledge from these educational opportunities. Recordings of compliance Webinars from MedAssets are currently available for playback through Oct. 31, 2011. These titles include the following:

- Chargemaster Structure and Maintenance
- Coding Vascular Access for Dialysis
- ICD-10: Introduction to the Diagnosis Codes
- ICD-10 PCS: Introduction to the Inpatient Coding Changes
- Laboratory Compliance, Coding and Billing Update
- Pharmacy Billing and Coding Best Practices

Recordings may be reviewed at your convenience.

Please note: MedAssets is no longer offering CEUs for recorded Webinars. If you are interested in viewing recorded Webinars, please contact your MedAssets account manager or e-mail [productsupport@medassets.com](mailto:productsupport@medassets.com) for additional information.

## CCFN WORD SEEK ANSWERS

S		I	P	P	S	E	L	U	R	
E	D	O	C	U	M	E	N	T	O	
C	M	S	E	V	E	N		E	O	
T				E	D	O	C	S	T	O
I								I	A	T
O	P				V			P		P
N	R	C	E	O				P		E
	B	O	D	Y	P	A	R	T	R	
Q		C	M		P		O		A	
U	G	E	M	S	S		A		T	
A		D	P	A	M		C		I	
L	G	U			E		H		O	
I	R	R				T	R	A	I	N
F	D	E				S		P		
I	S	S	R	E	Y	A	P	C		
E	M	E	D	A	S	S	E	T	S	
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					I	C	D			C
D	I	A	G	N	O	S	I	S		
						B				
		K	L	A	W	S	S	O	R	C
		P	R	O	V	I	D	E	R	

## Trade Shows and Events

OCTOBER 9-12

### Cerner Health Conference 2011

Kansas City, MO • Booth: TBD  
[View Website](#)

OCTOBER 12-14

### HIGPA International Expo

Washington, D.C. • Reverse Expo Format  
[View Website](#)

**General Session: The State of the Industry: Perspectives from GPO Executives** presented by Rand Ballard, Senior Vice President, Chief Operating Officer and Chief Customer Officer, MedAssets; Todd Ebert, President and Chief Executive Officer, Amerinet, Inc.; Jody Hatcher, President and Chief Executive Officer, Novation, LLC; Mike Alkire, President, Premier Purchasing Partners, LP; Moderated by: Don Black, President and Founder, Don Black Healthcare Strategy

**General Session: Strengthening Ties Between GPOs and Suppliers** presented by Mark Miriani, Senior Vice President, Supplier Relations, MedAssets; Cathy Denning, Vice President, Sourcing Operations, Novation, LCC; Ed Jones, Chief Operating Officer, Health Trust Purchasing Group; Tim Revash, Group Vice President, Purchasing Services, Child Health Corporation of America; Randall Walter, Executive Vice President, Amerinet, Inc.; Moderator: Rick Dana Barlaw, Senior Editor, Healthcare Purchasing News

OCTOBER 12-14

### First National Bundled Payment Summit

Washington, D.C. • Booth 7  
[View Website](#)

October 13 at 2:00 p.m. EST

**Lessons Learned Through the Implementation of the PROMETHEUS ECR Engine** presented by Gilbert D'Andria, Vice President, B2B and Payor Technologies, MedAssets and Mah-J Soobader, Vice President, Product Management, MedAssets

OCTOBER 16-19

### Leading Age Annual Conference (formerly AAHSA)

Washington, D.C. • Booth: 2106  
[View Website](#)

OCTOBER 23-26

### MGMA 2011 Annual Conference

Las Vegas, NV • Booth 935  
[View Website](#)

October 24 at 2:40 p.m. PST

### Healthcare Operating Costs – Fight or Flight?

presented by Tonia Kraus, Senior Vice President, Spend Management, Alternate Care, MedAssets

OCTOBER 26-28

### HFMA's MAP (Measure.Apply.Perform) Event

Miami, FL • Booth TBD  
[View Website](#)

October 26 at 3:30 p.m. EST

### Stanford University Hospitals and Clinics: Taking Charge of Your Charge Capture

presented by Kathie Campbell, Director, CDM & Revenue Capture, Stanford University Hospitals & Clinics and Rebecca Haworth Campbell, RN, MHA, Senior Director, Revenue Cycle Consulting, MedAssets

NOVEMBER 15

### Live Event – Contrast Media

[View Website](#)

### Pre-Commitment Program

### Live Event – Contrast Media

MedAssets will host its next Pre-Commitment Program in Plano, TX in November for providers looking to save on commodity supplies. To register, please email [precommit@medassets.com](mailto:precommit@medassets.com).

NOVEMBER 16-19

### ASCP Senior Care Pharmacy '11

Phoenix, AZ • Booth 827  
[View Website](#)

DECEMBER 4-8

### 46th ASHP Midyear Clinical Meeting

New Orleans, LA • Booth TBD  
[View Website](#)

## FREQUENTLY ASKED QUESTIONS

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

**Q** In a hospital ER department if a patient comes in twice a day but is treated for the same diagnosis would you use Modifier 27 and G0 code on the claim or if they come in twice with a different diagnosis would you use Modifier 27 and G0?

**A** The patient's diagnosis does not affect the triggering of CCI edits. The edits are based on the services and procedures provided to the same patient on the same date of service by the same provider. If two evaluation and management visits were provided to the same patient at different times during the same day, the multiple visits can be explained by using the Modifier 27 on the second visit and reporting condition code G0 on the claim if the same revenue code such as 0450 is involved.

**Q** I have heard that coders will need to take an Anatomy and Physiology course in preparation of ICD-10, who exactly is this for?

**A** ICD-10 has much greater specificity than ICD-9. More detailed information regarding anatomy & physiology (A&P) may be needed by people involved with code selection. One facility has made an internal policy that their coders needed to take an A&P class if they have been out of their educational program for more than two years. While your facility may not require this stringent of a policy, it is under consideration by at least one facility. The decision for your facility may not be the same, as you may determine that access to detailed anatomical charts or some other resource, may fit your needs better.

While A&P doesn't change, the application of the knowledge may be rusty if not used. One of the examples used in the presentation was sinusitis, and the specificity for the different nasal sinus compartments. Knowing the difference between maxillary, frontal, ethmoid, sphenoid and pansinusitis will become necessary for accurate coding.

### Some Commercial Payors Are Not Converting to ICD-10?

*...Continued from page 13*

problematic if applied to convert ICD-10 back to ICD-9-CM when used with other types of ICD-9-CM payment applications.

MedAssets has been working diligently with mapping the five percent of ICD-10-CMs that have a one-to-many relationship as well as the four percent of the ICD-10-PCS with a one-to-many relationship and codes that have a no-match relationship. This approach bridges the gap between medical record coding and clinical documentation with the specificity of ICD-10. What makes MedAssets stand apart from other organizations is that its coding experts take a best practice approach by evaluating cases on a DRG by DRG basis that, unlike

other organizations, might uniformly apply a single choice among mapping alternatives.

In conclusion, although payors that do not convert to ICD-10 would be avoiding expensive reprogramming to their payment applications, it would cause significant problems for their providers including reimbursement outcomes. MedAssets is here to assist with helping providers and payors implement ICD-10CM-PCS with its Best Practice approach.

#### About the Author

Zuriharri Pannell is a charge and revenue analyst. Zuriharri is a member of the

Integrity Services team and supports ICD-10 at MedAssets. As a healthcare professional, Zuriharri has more than eight years of experience. In her previous roles she has held positions as a billing specialist, appeals coordinator and patient account/collector in physicians' offsite billing offices, corporate billing, collections, and reimbursement departments.

#### REFERENCES

[www.cms.info\\_bulletin\\_7-20-11](http://www.cms.info_bulletin_7-20-11)  
[www.icd10watch.com](http://www.icd10watch.com)  
[www.ahima.library.org](http://www.ahima.library.org)

## CCFN WORD SEEK

OCTOBER 2011

By Pamela Pfeifer

(See page 14 for answers.)

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> APPROACH    | <input type="checkbox"/> OPPTS          |
| <input type="checkbox"/> BODY PART   | <input type="checkbox"/> PAYORS         |
| <input type="checkbox"/> BODY SYSTEM | <input type="checkbox"/> PCS            |
| <input type="checkbox"/> CDM         | <input type="checkbox"/> PROCEDURE      |
| <input type="checkbox"/> CM          | <input type="checkbox"/> PROVIDER       |
| <input type="checkbox"/> CMS         | <input type="checkbox"/> QUALIFIER      |
| <input type="checkbox"/> CODE        | <input type="checkbox"/> ROOT OPERATION |
| <input type="checkbox"/> CROSSWALK   | <input type="checkbox"/> RULES          |
| <input type="checkbox"/> DEVICE      | <input type="checkbox"/> SECTION        |
| <input type="checkbox"/> DIAGNOSIS   | <input type="checkbox"/> SEVEN          |
| <input type="checkbox"/> DOCUMENT    | <input type="checkbox"/> SYSTEM         |
| <input type="checkbox"/> GEMS        | <input type="checkbox"/> TEST           |
| <input type="checkbox"/> ICD         | <input type="checkbox"/> TRAIN          |
| <input type="checkbox"/> IPPS        |   |
| <input type="checkbox"/> MAP         |   |
| <input type="checkbox"/> MEDASSETS   |   |
| <input type="checkbox"/> MSDRG       |   |

S T I P P S E L U R  
 E D O C U M E N T O  
 C M S E V E N S E O  
 T Z Q I E D O C S T  
 I Q P P Z B I A T O  
 O E P T E V R P E P  
 N M R C E O F P A E  
 L B O D Y P A R T R  
 Q C C M T P T O S A  
 U G E M S S H A S T  
 A P D P A M S C Y I  
 L G U B V E P H D O  
 I R R J O T R A I N  
 F D E H M S C P T P  
 I S S R O Y A P C H  
 E M E D A S S E T S  
 R U K L S Y S T E M  
 M X L I C D S V A C  
 D I A G N O S I S A  
 O Q Z P K B F Q F I  
 L K L A W S S O R C  
 I P R O V I D E R O

## Tell Us What You Think

CCFN has been in continuous publication since 2004. We'd like to know what you think. What would you like to see? What subjects would you like us to cover? Send us an e-mail ([compliance2@medassets.com](mailto:compliance2@medassets.com)) and tell us what you think.

## CCFN STAFF CREDITS

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