VOLUME 32 NUMBER 9 September 2015

PRESCRIPTIONS

BOONE COUNTY MEDICAL SOCIETY

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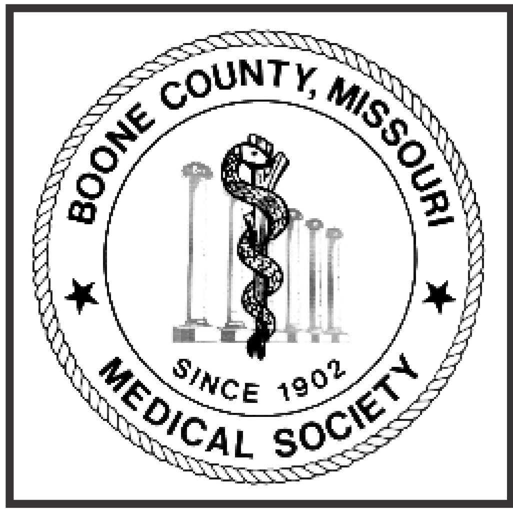
BOONE COUNTY MEDICAL SOCIETY



Prescriptions is published monthly for members of the Boone County Medical Society (physician members in Boone, Cooper and Howard Counties) Deadline for submission of materials is the first of each month preceding publication.

*Disclaimer: BCMS does not assume responsibility for the statements of authors and opinions expressed are not necessarily those of ***Prescriptions*** or the BCMS nor should publications or advertisements be considered an endorsement by the BCMS.

TO TELL US
WHAT'S ON YOUR MIND!!!

PHONE: (573) 814-1894
FAX: (573) 814-3765
EMAIL: bcms@socket.net

ADDRESS:

Boone County Medical Society
Box 196
Columbia, MO 65205

PRESCRIPTIONS

VOLUME: 32 ISSUE: 9

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PRESCRIPTIONS MISSION STATEMENT:
"The Boone County Medical Society "*Prescriptions*" is to be used for communication among its members; to inform members of activities, highlight membership concerns and promote camaraderie. It is also intended as a forum to address community health needs."

BY THE WAY

By: Beverly Wilcox,
Executive Director, Boone County Medical Society

Do you know your board members, those persons you elected to serve as your BCMS office and board?
You should!

Do you know which committees your board members are on?
You should!

Do you let your board members know your concerns?
You should!

Do you offer your board members your support?
You should!

About here you are asking, Why should I?

Well, each officer and board member, which you elected works very hard to promote and accomplish the work that it takes to carry out the functions for BCMS and to do an effective job these physicians need your help, support and cooperation.

They also need you to be informed from their end; therefore the following are some of things the board is doing to move BCMS forward and in the process working to serve your organization in an effective manner.

Currently these are the projects your officers and board are working on to keep BCMS fresh and relevant:

- Preparing your slate of Officers for 2016
- Keeping your 2016 dues the same
- Updating the Mission Statement
- Putting into effect a long range plan for finances
- Working hard to collect member's emails
- Putting together a 5th annual tailgate event with the Alliance
- Membership has put together a new survey and you can respond via survey monkey, mail, email or fax
- Changed the timeframe that our two scholarships are awarded. Deadline date for submission is September 1
- Formulating a fall public forum debate on a “hot” topic
- Working on the January 2016 Gala
- Preparation work has begun on the nominations for Doctor of the Year
- Scheduling CME/DIG speakers for 2016
- BCMS website should be up and running sometime this fall
- Your BCMS Bylaws have been reviewed and we are in the long drawn out process of rewriting them

These are but just some of the projects that have been undertaken this year on your behalf.

Your BCMS officers and board members take the job you have entrusted to them very seriously and they strive to make prudent and informed decisions on your behalf. They certainly need your help, cooperation and support in all areas needed to promote and keep BCMS alive and well. There is a great deal of work that goes on behind the scene. When you receive a survey, a call, an invitation or whatever – please help BCMS out by participating – it's your local organization. I know physicians have been hit with some huge scary expensive changes such as the Affordable Care Act, electronic medical records and now on October 1 ICD 10.

But Together we can help make a difference in medicine

By the way, next time you see these fellow colleagues, tell them how much you appreciate all of the time they provide to the making of your organization---BCMS--- better.

Officers: **Bridget Early, Hung Winn, Raghav Govindarajan**

Board: **John Pardalos, Mark Janzen, Rich Nichols, George Parkins, Steve Keithahn and Ashish Nanda**

2015 BOONE COUNTY MEDICAL SOCIETY
DOCTOR OF THE YEAR
NOMINATION FORM

Nominations for the BCMS Doctor of the Year Award are being solicited. This award will be given annually only if there is a nominee who meets the following criteria.

To be eligible, the nominee must: (1 and 2 are mandatory)

1. Be a member in good standing of BCMS, who has made a significant contribution in his/her practice of medicine, and be nominated by a fellow BCMS member.
2. Have a minimum of 15 years in the practice of medicine with at least five year of practice in Boone, Howard or Cooper Counties.

The ideal nominee will meet at least ONE of the criteria described below:

3. Local, state or national recognition in their specialty.
4. Significant contributions to medical research, teaching or scientific publications.
5. Significant contributions to organized medicine outside of Boone, Howard or Cooper Counties.
6. Significant community involvement outside of medicine.
7. Noteworthy humanitarian efforts on a local, national or international level.

The BCMS Doctor of the Year Committee and the Board of Directors will select the recipient and the winner will be notified by the Board President. The award will be presented during the Annual Gala/General Membership Meeting held on January 23, 2016. (Whenever possible, the person who nominates the recipient will be asked to aid in the presentation of the award.)

Complete the information below and return it with your letter of support and your nominee's CV **no later than November 1, 2015 to:**

BCMS
Box 196, Columbia, MO 65205-0196
FAX: 573/814-3765 or EMAIL: bcms@socket.net

Nominee's Name: ____________________

Years in Practice in Boone, Howard or Cooper Counties: ____________________

Your Name: ____________________

Your Phone Number: ____________________ Your Email Address: ____________________

BOONE COUNTY MEDICAL SOCIETY
Box 196
Columbia, MO 65205
Phone: 573.814.1894
Fax: 573.814.3765
Email: bcms@socket.net

2015 MEMBERSHIP QUESTIONNAIRE
Return to BCMS by using survey monkey, email, fax or mail
Deadline to submit - September 15, 2015

https://www.surveymonkey.com/r/bcms2015

The Membership Committee of Boone County Medical Society (BCMS) would like to make your membership the best experience possible. Please take a couple minutes to tell us how we can better serve you.

1. Why are you a member of the Boone County Medical Society?
   - o Networking at meetings/events
   - o Support organized medicine
   - o CME events
   - o Other:

2. What can BCMS do to enhance your membership experience? Please be specific.

3. Have you attended a meeting of BCMS in the past couple years?

   If yes, what have you enjoyed most about our meetings?

   If no, why have you not attended any meetings? How can we improve to meet your busy schedule?

4. How important is it that we are offering CME again for our general membership meetings?
   - o Important
   - o Somewhat
   - o Not important

5. We have approximately 300 members, yet our CME/general membership and DIG dinner meetings draw about 30 physicians on average. Suggested changes we could make to increase attendance.

6. What projects or causes would you like to have BCMS use your membership dues for?

7. Do you feel like the BCMS board is available and responsive to your concerns?
   - o Yes
   - o No. If no, please let us know how to improve.

8. I have a special interest in assisting with one or more of the following topics.
   - o Public Health
   - o Membership and Recruitment
   - o Public Relations and Legislation
   - o Publications
   - o Resolution Drafting
   - o Delegate to MSMA Convention (3/18-20/16 Renaissance Hotel, St. Louis)
   - o CME
   - o Ladenson or BCMS Scholarships
   - o Gala/Installation held in January each year

9. I may be interested in serving as an officer or board member.
   - o Yes
   - o No

10. What meeting topics/speakers would you be interested in hearing?

11. I have an article I would like to have published in the monthly newsletter (email in word format to BCMS office).

12. Would your spouse be interested in learning more about the BCMS Alliance?
   - o Yes
   - o No

   How can we contact them with this information?

13. I have additional questions and would like to be contacted? (Let us know the best way to do this.)

Name ________________________ Email ______________________ Phone __________

HAPPY BIRTHDAY
TO OUR MEMBERS

SEPTEMBER

9/03	W. Kirt Nichols
9/03	Juan Jose Pineda
9/07	Diane T. Brukardt
9/07	David Pittman
9/08	Sanjeev D. Ravipudi
9/10	Winston E. Harrison
9/13	Don J. Gibson
9/14	Michael Richards
9/15	John W. Yarbro
9/17	Charles P. Bondurant
9/20	Cathy Jo Cody
9/22	Anne B. Fitzsimmons
9/27	Kari Martin
9/28	Robert P. Zitsch III
9/29	C. E. Gene Ridenhour
9/29	Frederick Fraunfelder
9/29	Blake J. Brooks
9/30	Wm. Corwin Allen

New Members:

Stephen Griffith
One Hospital Drive
Columbia, MO EM

Paula McMurtry
1705 E. Broadway #220
Columbia, MO 65201 RHU

Welcome to BCMS. We look forward to seeing you at some of our events so you can meet some of your colleagues.

Boone County Medical Society
&
Boone County Medical Society Alliance

5th Annual Football Tailgate

Mizzou ***Florida Gators***
October 10th ***Time: TBD***

Watch your mail for invitation.

! CHANGE OF LOCATION !

MONTHLY RETIRED PHYSICIAN LUNCHEON

Retired physician luncheon meets on the 3rd Wednesday of each month at 12:00PM (noon)

Babbo's
1305 Grindstone Parkway,
Columbia, MO 65203

No reservation needed,
just show up.

ICD-10-CM/PCS MYTHS AND FACTS

This fact sheet provides the following information on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS):

- ICD-10-CM/PCS compliance date;
- Use of external cause and unspecified codes in ICD-10-CM;
- Responses to myths on ICD-10-CM/PCS;
- Resources.

When "you" is used in this publication, we are referring to health care providers.

ICD-10-CM/PCS COMPLIANCE DATE

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes.

USE OF EXTERNAL CAUSE AND UNSPECIFIED CODES IN ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity. If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

RESPONSES TO MYTHS ON ICD-10-CM/PCS

MYTH

ICD-10-CM/PCS implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the October 1, 2015, compliance date.

FACT

All HIPAA-covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2015. HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2015.

MYTH

Non-covered entities, which are not covered by HIPAA such as Workers' Compensation and auto insurance companies, that use ICD-9-CM may choose not to implement ICD-10-CM/PCS.

FACT

Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in non-covered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to non-covered entities. The Centers for Medicare & Medicaid Services (CMS) will work with non-covered entities to encourage them to use ICD-10-CM/PCS.

MYTH

State Medicaid Programs will not be required to update their systems to use ICD-10-CM/PCS codes.

FACT

HIPAA requires the development of one official list of national medical code sets. CMS will work with State Medicaid Programs to ensure that ICD-10-CM/PCS is implemented on time.

MYTH

The increased number of codes in ICD-10-CM/PCS will make the new coding system impossible to use.

FACT

Just as an increase in the number of words in a dictionary doesn't make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn't necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS make it easier for you to find the right code. In addition, just as you don't have to search the entire list of ICD-9-CM codes for the proper code, you also don't have to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools are available to help you select the proper code. The improved structure and specificity of ICD-10-CM/PCS will likely assist in developing increasingly sophisticated electronic coding tools that will help you more quickly select codes. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

MYTH

ICD-10-CM/PCS was developed without clinical input.

FACT

The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

MYTH

No hard copy ICD-10-CM and ICD-10-PCS code books will be available. When ICD-10-CM/PCS is implemented on October 1, 2015, all coding will need to be performed electronically.

FACT

ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher's book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

MYTH

ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

FACT

Prior to the implementation of the partial code freeze, ICD-10-CM/PCS codes had been updated annually since their original development to keep pace with advances in medicine and technology and changes in the health care environment. The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze where

only codes capturing new technologies and new diseases would be added to ICD-9-CM and ICD-10. The code freeze resulted in the following updates:

- On October 1, 2011, the last regular, annual updates were made to both code sets;
- On October 1, 2012, October 1, 2013, and October 1, 2014, only limited code updates for new technologies and new diseases were made to both code sets as required by Section 503(a) of Public Law 108-173;
- On October 1, 2015, only limited code updates for new technologies and new diseases will be made to the ICD-10 code sets to capture new technologies and diseases. No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and
- On October 1, 2016, regular updates to ICD-10 will resume.

MYTH

Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented on October 1, 2015.

FACT

As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation, but is not currently needed for ICD-9-CM coding.

MYTH

ICD-10-CM-based super bills will be too long or too complex to be of much use.

FACT

Practices may continue to create super bills that contain the most common diagnosis codes used in their practice. ICD-10-CM-based super bills will not necessarily be longer or more complex than ICD-9-CM-based super bills. Neither currently-used super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions. The super bill conversion process includes:

- Conducting a review that includes removing rarely used codes; and
- Crosswalking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEMs).

MYTH

The GEMs were developed to provide help in coding medical records.

FACT

The GEMs were not developed to provide help in coding medical records. Code books are used for this purpose. Mapping is not the same as coding because:

- Mapping links concepts in two code sets without consideration of patient medical record information; and
- Coding involves the assignment of the most appropriate code based on medical record documentation and applicable coding rules/guidelines. The GEMs can be used to convert the following databases from ICD-9-CM to ICD-10-CM/PCS:
- Payment systems;
- Payment and coverage edits;
- Risk adjustment logic;
- Quality measures; and
- A variety of research applications involving trend data.

MYTH

Each payer will be required to develop their own mappings between ICD-9-CM and ICD-10-CM/PCS as the GEMs developed by CMS and the Centers for Disease Control and Prevention (CDC) are for Medicare use only.

FACT

The GEMs are a crosswalk tool that was developed by CMS and CDC for the use of all providers, payers, and data users. The mappings are free of charge and are in the public domain.

MYTH

Medically unnecessary diagnostic tests will need to be performed to assign an ICD-10-CM code.

FACT

As with ICD-9-CM, ICD-10-CM codes are derived from documentation in the medical record. Therefore, if a diagnosis has not yet been

established, you should code the condition to its highest degree of certainty (which may be a sign or symptom) when using both coding systems. In fact, ICD-10-CM contains many more codes for signs and symptoms than ICD-9-CM, and it is better designed for use in ambulatory encounters when definitive diagnoses are often not yet known. Nonspecific codes are still available in ICD-10-CM/PCS for use when more detailed clinical information is not known.

MYTH

Current Procedural Terminology (CPT) will be replaced by ICD-10-PCS on October 1, 2015.

FACT

ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will not affect the use of CPT.

MYTH

When ICD-10-CM codes replace ICD-9-CM codes on October 1, 2015, it will impact how I report CPT and Healthcare Common Procedure Coding System (HCPCS) codes.

FACT

When ICD-10-CM codes replace ICD-9-CM codes on October 1, 2015, it will not impact how you report CPT and HCPCS codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, you should continue to follow CPT and CMS guidance when you report CPT/HCPCS modifiers for laterality.

Reprinted from Centers for Medicare & Medicaid Services: June 18th, 2015 - MLN Connects Provider eNews

6 Things You Need To Know About The ICD-10 Transition

The Centers for Medicare & Medicaid Services (CMS) is making the transition to the ICD-10 code set more flexible, but there are several clarifying points physicians should know.

1. ICD-10 will not be delayed. The deadline to switch to ICD-10 remains Oct.1, although CMS has agreed to flexibilities for Medicare Part B claims that should help make that transition smoother.

2. Medicare claims with a date of service on or after Oct. 1 will be rejected if they do not contain a valid ICD-10 code.

ICD-10-CM is composed of codes with between three and seven characters. Codes with three characters act as the heading of a category of codes and can either be further subdivided to provide greater specificity (which would add characters) or stand alone.

A complete list of valid codes and code titles is on the CMS website and listed in tabular order, the same order in the ICD-10-CM codebook.

3. A "family of codes" is the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For example, category H25—age-related cataract—contains a number of specific codes that captures information about the type of cataract and information on the eye involved.

With few exceptions (described in more detail below), Medicare Part B claims will not be denied or subject to an audit solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

4. Certain claims fall outside of the coding flexibility. In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. Check CMS' document for more information.

5. These flexibilities do not extend to prior authorization requests. The flexibilities only pertain to claims processing and post-payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization.

6. CMS' changes do not affect Medicaid or commercial payers. The official guidance only applies to Medicare fee-for-service claims from claims by physicians and other practitioners that are billed under the Medicare Fee-For-Service Part B physician fee schedule. It does not apply to claims submitted for beneficiaries with Medicaid coverage. Check CMS' document for more information.

Reprinted from July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities.

Boone County Medical Society
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Columbia, MO 65205-0196

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