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## 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**ICD-9 is more than 30 years old and outdated.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.

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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 *continued page 7*

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**EDWARD FELLER, MD**, received the Medical Senior Citation from graduating Brown medical students for the sixth time last year. Dr. Feller is the most frequent recipient of this prestigious award in the history of medical education at Brown. Each year the Brown graduating class presents the Senior Citation to the most outstanding faculty mentor and role model encountered during their medical school years. Dr. Feller is Clinical Professor of Medicine and Community Health and co-director of the Community Health clerkship at Brown.

The Rhode Island Pain Society is the Ocean State's newest medical society. Officially established in July 2009, the Society brings together anesthesiologists, physiatrists, neurologists, rheumatologists, chiropractors and others who have an interest in pain management. The inaugural officers are: **MATTHEW SMITH, MD**, President; **CASEY O'DONNELL, DO**, Vice-President; **TODD HANDEL, MD**, Secretary; **ADRIAN HAMBURGER, MD**, Treasurer. The officers welcome inquiries regarding the Pain Society. Dr. Smith can be reached at [smith@egss.us](mailto:smith@egss.us) or 401-886-5907.

**PAMELA C. HIGH, MD**, has been elected President of the Society for Developmental and Behavioral Pediatrics, an international organization dedicated to improving the health of infants, children and adolescents by promoting research, teaching and clinical practice in developmental and behavioral pediatrics. Dr. High serves on the staff of Hasbro Children's Hospital and the faculty of the Warren Alpert Medical School at Brown. Her community service includes the advisory board of Reach Out and Read Rhode Island and the board of directors of Rhode Island Kids Count.

The **DR. MICHAEL B. MACKO** Library and Conference Room was dedicated by the medical staff of the Roger Williams Medical Center on November 30, 2009. Dr. Macko served as President of the Rhode Island Medical Society 2000–2001, as a member of Rhode Island's Delegation to the AMA 2004–2008, and as a member of RIMS' Committee on Continuing Medical Education for eleven years. Dr. Macko retired in December and died on January 24, 2010, after a long illness. ❖

## 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. HHS 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 makes information and code set files available on its website: [www.cdc.gov/nchs/icd/icd10.htm](http://www.cdc.gov/nchs/icd/icd10.htm).

The American Medical Association's website ([ama-assn.org](http://ama-assn.org)) is an invaluable source for on-going 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](http://ama-assn.org/go/hippa)). This AMA document provides practical advice on taking the following 8 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 vendor.
- 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. ❖