

## ISEPS Coding Update

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### ICD-10 Effective October 1, 2015

Well it finally happened!!! Medicare claims with a date of service on or after 10/01/2015 are only accepted if they contain a valid *ICD-10* code.

### **LCD Updated - Missing Diagnosis Coded Added**

National Government Services (NGS), the J-6 Part A/B Medicare Administrative Contractor notified ISEPS that the missing diagnosis codes in the Local Coverage Decision (LCD) for Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (L33567) have been added to the list of *ICD-10* codes that support medical necessity for Group 1 *CPT* codes 92225, 92226, 92228, and 92250.

The following diagnosis codes should support medical necessity effective with dates of service on or after 10/01/2015. Denied claims can be reopened through CONNEX or by requesting a telephone reopening.

- H40.10X1 Unspecified open-angle glaucoma; mild stage
- H40.10X2 Unspecified open-angle glaucoma; moderate stage
- H40.10X3 Unspecified open-angle glaucoma; severe stage
- H40.10X4 Unspecified open-angle glaucoma; indeterminate stage

Please notify ISEPS of any problems you are having with payers accepting *ICD-10* codes. In addition to describing the scenario, please be sure to include a copy of the claim submitted to the payer as well as a copy of the explanation of benefits showing the remark codes related to the specific claim.

### **Clarification**

There has been some misunderstanding about the Centers for Medicare & Medicaid Services (CMS) announcement regarding the temporary flexibility in the claims auditing and quality reporting during *ICD-10* implementation.

- For 12 months after *ICD-10* implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the *ICD-10* diagnosis code as long as the physician/practitioner **used a code from the right family**. However, a valid *ICD-10* code will be required on all claims starting on October 1, 2015.
- For all quality reporting completed for program year 2015, Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalties during primary source verification or auditing **related to the additional specificity** of the *ICD-10* diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to *ICD-10* codes.

This announcement did not mean that there was any delay in the implementation of *ICD-10*. What it does mean is that CMS is willing to continue to process claims that include unspecified codes from the correct family of codes.

“Family of codes” is the same as 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 capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Thus, even though a “family of codes” is a three-character category, the physician must report a valid code. If the physician’s documentation does not allow for reporting to the greatest extent known at the time of service, e.g., type of cataract and laterality, because the assessment only includes “cataracts,” the coder can only assign H25.9. Due to the clarification above, CMS will accept H25.9 for claims processing for dates of service 10/01/2015 through 09/30/2016.

CMS’ clarification also explained that this flexibility guidance does not change the coding specificity required by the National Coverage Decisions (NCDs) and LCDs. According to CMS, coverage policies that required a specific diagnosis under *ICD-9* will continue to require a specific diagnosis under *ICD-10*. It is important to note that these policies should not require any greater specificity in *ICD-10* than was required in *ICD-9*, **with the exception of laterality**, which does not exist in *ICD-9*. LCDs and NCDs that contain *ICD-10* codes for right side, left side or bilateral do not allow for unspecified side.

Of special note, CMS has made it very clear that there is **no guarantee other payers** will allow the use of unspecified codes (especially for primary diagnoses – reason for the encounter – which should be the first diagnostic statement in the assessment section of the progress note and listed as the first diagnosis on the claim). Physicians should verify with their major commercial payers to determine whether the unspecified codes from the same family of codes will be accepted on claims.

While this temporary reprieve from using the *ICD-10* code that represents the greatest extent known at the time of the encounter is tempting, physicians should consider whether it is wise to simply report unlisted codes for the first year of implementation. At some point, greater specificity will be required. Newby Consulting (NCI) recommends that to the extent possible, physicians should use the more specific codes now, so additional changes will not be necessary in the future.

### **Using Scribes**

We continue to receive questions about whether technicians and scribes need to be certified. Some physicians are complaining that they are receiving two different answers to the question. We believe the inconsistent responses are being given because there are two (2) separate issues related to the licensure/certification requirements for someone other than the physician/provider entering information in the practice’s electronic health record (EHR).

The correct response to the specific question is that **certification is not required to scribe** for the physician.

The problem is if the scribe is not certified or a licensed health care professional, the physician should not count orders entered by this scribe in the EHR’s computerized provider order entry system (CPOE) for the purposes of meeting the meaningful use objective.

For meaningful use, the physician can only count the entries personally documented by the physician or by licensed or certified personnel.

Most ophthalmologists should consider using certified personnel to scribe the records so the physician does not have to personally enter orders in the CPOE. Please remember, this recommendation does not mean physicians must use certified ophthalmic technicians as scribes.

To assist ophthalmologists in meeting this meaningful use measure, the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) created the Ophthalmic Scribe Certification (OSC) examination. See the JCAHPO website at <http://www.jcahpo.org/marketplace/detail.aspx?id=JCEX1000>

## **Background/Reference Information**

### ***Scribes***

Using a scribe means the physician is utilizing someone else to document the work performed by that physician, in either an office or facility setting. In Evaluation and Management (E/M) services, surgical, and other such encounters, the “scribe” does not act independently. The “scribe” contemporaneously documents the physician's dictation and/or activities during the visit. The physician who receives the payment for the service is expected to be the person delivering the service and creating the record, which is simply “scribed” by another person.

The following information was copied from the NGS website (article is not all inclusive):

### **Scribing Medical Record Documentation**

National Government Services recognizes an increasing trend in providers' use of scribes as assistants in medical record documentation. In these situations, a provider utilizes the services of staff to document work performed by the provider, in either an office or a facility setting.

In documenting any patient encounter, **the scribe neither acts independently nor functions as a clinician**, but simply records the provider's dictated notes during the visit. The provider who receives the payment for the service is expected to deliver the service and is responsible for the medical record; **the scribe may simply enter information on the provider's behalf, all of which must be corroborated (i.e. approved) by the provider.** *[Emphasis added]*

**Some electronic medical record programs allow the provider to amend the scribe's entry before the provider signs and enters the note into the record;** this is permissible. When a scribe enters on a paper medical record and correction is needed, the provider must add and sign an addendum to the scribe's note, rather than cross out or alter what the scribe has written. *[Emphasis added]*

During a patient encounter, the scribe may additionally perform standard medical assistant functions, as long as the scribe remains available to the provider and free to document the provider's verbal observations in real time. The act of scribing is **intended to take place as the provider dictates his/her notes regarding the patient's history, exam and plan of care.** The scribe is **not permitted to record any independent notes, but only those specifically dictated by the provider.** *[Emphasis added]*

Physicians using the services of a “scribe” must adhere to the following:

- Physician cosigns the note indicating the note is an accurate record of both his/her words and actions during that visit.
- Record entry notes the name of the person “acting as a scribe for Dr. \_\_\_\_\_”

- Documentation supports both the medical necessity of the level of service billed and the level of the key components required of the service. See Related Content for E/M guidelines.

In the office setting, a staff member may independently record the past, family and social history (PFSH) and the review of systems (ROS), and may act as the provider's scribe, by simply documenting the provider's words and activities during the visit. The provider may count that work toward the final level of service billed. However, the provider must document that he/she reviewed this information.

Scribe usage may be appropriate and included in a Medicare provider's practice, when properly administered and documented. The Medicare provider must assume full responsibility for the performance, documentation, coding and billing of any scribed service.

Clarification of what services can be performed by clinical staff and scribes is included in the article titled "Evaluation and Management Frequently Asked Questions" on the NGS website (information below is not all inclusive)

18. I have heard that four or five years ago NGS issued some sort of correspondence which stated that the history of present illness can only be documented by the provider. I have not been able to find this on the NGS website but have seen it referenced by Yale, among others. Can you verify this?

Answer: There are two elements of history that can be elicited and documented by someone other than the provider: the Review of Systems (ROS) and the Past, Family and Social History (PFSH). A staff member or medical student may elicit this information from the patient, but the provider is obliged to review it, amend it if necessary, and indicate in writing that he/she has done so.

The **provider is responsible for eliciting and documenting the History of the Present Illness (HPI), since this requires defined clinical skill.** That said, the provider may utilize the services of a scribe in documenting the HPI, as with any other element of an E/M service. *[Emphasis added]*

22. When an RN acts as a scribe, does the documentation have to state that the RN was utilized as a scribe? What if the RN is used at the scribe and it is electronic medical record?

Answer: **The documentation should state the name and title of the scribe**, whether the scribe is a licensed employee or ancillary office staff. This should be included in the record, whether it is written or electronic. *[Emphasis added]*

Physicians using scribes should review their documentation (applies to paper records and EHRs) to confirm the required statements are entered in the patient medical records. In our experience, the vast majority of audits start with a request to provide copies of the patient's medical record. When reviewing EHR documentation, we recommend printing the progress note to ensure the required information is present.

### ***Meaningful Use Criteria for Stage 1 and Stage 2 Meaningful Use Measure #1***

For both Stage 1 and Stage 2 Meaningful Use, to count orders entered in the CPOE, the individual must be a licensed healthcare provider OR a licensed or certified healthcare professional who meets the state, local and professional guidelines (if applicable) to enter orders for medication (Stage 1) or medication, laboratory, and radiology orders (Stage 2).

Although the description of the Stage 1 Meaningful Use Objective #1 CPOE for Medication Orders continues to only include “licensed healthcare professionals,” CMS clarified that effective 1/1/2013, in frequently asked question (FAQ) 7693.

Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator?

We have revised the description of who can enter orders into the EHR and have it count as CPOE and have it count for purposes of the CPOE measure. This revision is available for EHR reporting periods in 2013 and beyond regardless of what stage of meaningful use the provider is attesting to. (FAQ7693)

The description in the objective section of the Stage 2 CPOE for Medication, Laboratory and Radiology Orders, only includes “orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines” CMS provides the following clarification under “Additional Information.”

Any licensed healthcare professionals and credentialed medical assistants, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.