

MDS Alert

ICD-10, Payment, Clinical & MDS News

CMS has **not instituted any delay or elimination of ICD-10**, which means you'll need to be ready to use the new code set by Oct. 1, 2013 -- less than two years away. And contractors, vendors, and individual states are steadily readying their systems for ICD-10 claims processing.

Medicaid: Because Medicaid rules and policies vary on a state-by-state basis, you may be expecting states to be on different pages when it comes to ICD-10 implementation. But that would be an inaccurate assumption, CMS reps said during a Nov. 17 "ICD-10 Implementation" call.

"I can tell you that most states are still conducting impact analyses and gathering business requirements for the things needed to accommodate the implementation of ICD-10," said CMS' **Elizabeth Reed** during the call. "CMS currently conducts bi-weekly calls with the states and is currently offering state-specific technical assistance training. I would encourage providers to get on their respective state list serves to stay in tune with state communications and testing requirements," she added.

Procedure coding: Fortunately, Part B coders won't have to worry about using the procedural codes, known as ICD-10-PCS, because this code set will only be used for inpatient hospital claims, said CMS' **Pat Brooks** during the call.

"ICD-10-PCS will not be used on physician claims, even those for inpatient visits," Brooks told the callers. In addition, ICD-10 implementation has "no impact on CPT® or HCPCS coding -- they will continue to be used as they are now."

Coverage decisions: One caller to the forum asked whether CMS is working on converting diagnosis codes on the national coverage decisions (NCDs), which are currently listed in ICD-9 format, to ICD-10 codes. Brooks assured the caller that CMS reps are working on such a conversion, but no updates exist on how far along the conversion is at this point.

For more on ICD-10 implementation, visit the CMS Web site at www.cms.gov/ICD10/.

Editor's note: This article originally appeared in the Coding Institute's Part B Insider. For subscription information, call 1-877-912-1834.

Here's another reason to be up to speed with OMRAs. **Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA**, warns that "with the additional MDS 3.0 changes which took effect Oct. 1 ... it will only make it easier for the RACs or any other post payment auditor to find the money." He notes that "any time you increase the variables (as happened with the MDS 3.0 and the Change of Therapy and End of Therapy-Resumption OMRAs), you also increase the opportunity for errors. This means there will be more errors -- either COTs not done that should have been or EOT-Rs that should have been done and haven't been." And "the only way for CMS or their contractors to know if an error was made in these areas is to do an audit, as the claim itself will not show whether a COT should have been done and was not," adds Kintz, managing director of the Polaris Group based in Tampa, Fla.

Pauline Franko, PT, **MSCP**, says she's "seeing RACs written all over COT OMRAs because if you miss doing one when you should have -- it's essentially ... the equivalent of a technical denial, which has no appeal rights. You may be able to fight it but it's going to be really hard to do. That's my feeling about it and I hope I'm wrong, but it's a black and white issue. I hope RACs won't get involved in looking at this until after SNFs get used to doing the COT OMRAs."

Proactive strategy: Extendicare does "weekly calls with buildings to go through each patient to make sure we're not missing COTs or EOTs," says **Jim Hendricks, RN, BSN, RAC-CT**, area director of clinical reimbursement for the company based in Milwaukee, Wis.

The CDC recently published new hepatitis B vaccination guidance that could affect your residents. A Dec. 23 issue of the

agency's Morbidity and Mortality Weekly Report (MMWR) notes that "since 1996, a total of 29 outbreaks of HBV infection in one or multiple long-term-care (LTC) facilities, including nursing homes and assisted-living facilities, were reported to CDC; of these, 25 involved adults with diabetes receiving assisted blood glucose monitoring (1; CDC, unpublished data, 2011)."

The article goes on to state: "An estimate of the risk for HBV infection for adults with diabetes living in LTC facilities was not available; continuing outbreaks suggest that it might be substantial."

The Advisory Committee on Immunization Practices (ACIP) suggests that "Hepatitis B vaccination should be administered to unvaccinated adults with diabetes mellitus who are aged 19 through 59 years (recommendation category A; evidence type 2)," states the MMWR article. "Hepatitis B vaccination may be administered at the discretion of the treating clinician to unvaccinated adults with diabetes mellitus who are aged ≥ 60 years (recommendation category B; evidence type 2)."

"This recommendation is long overdue," comments **James Marx, RN, MS, CIC**, an infection preventionist with long-term care expertise. "Common use blood sugar testing equipment has long been recognized as a common source of bloodborne pathogens," says Marx, principal of Broad Street Solutions in San Diego, Calif. And "hepatitis B is vaccine preventable. While most young people under 30 years old born in the United States have been vaccinated, the large number of older diabetics are vulnerable. This is a new recommendation and not part of any enforceable regulation (as of now). Facilities should include hepatitis B vaccine screening as part of routine admission assessments," Marx tells Eli.

Do your SNF's **physicians use the MDS in this way?** "The MDS is actually one of the documents that I will go back to if I want to see where a resident has been over time," said **Karen Leible, MD, CMD, RN**, in a presentation on the MDS 3.0 at the March 2011 American Medical Directors Association annual meeting. "I will go back and look at their MDS rather than trying to flip through 17 different forms and folders or going back to an old chart," she told conferees.