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COMMENTARY

ICD-10 Transition

BY DR. MARGARET KLASA

The Department of Health and Human Services (HHS) extended its ICD-10 implementation deadline by two years, from October 1, 2011 to October 1, 2013, giving payors and provider organizations additional time to prepare for the transition. Payors and providers are now preparing and assessing how the new ICD-10 code sets will affect their IT systems and determining training needs of their staff.

The biggest difference between ICD-9 and ICD-10 is the vast increase in the number of diagnosis and procedure codes. The reason for this increase was that ICD-9 could simply not accommodate and expand to incorporate new diagnoses and procedures. On the other hand, ICD-10 is able to provide greater detail and ability to document conditions.

Both payors and providers will be impacted by the structure changes in ICD-10-CM code sets that their information systems will have to handle. Structural changes such as field length to accommodate the seven digit fields and the alphanumeric characters in ICD-10. Since the code sets for ICD-10 is much larger than ICD-9, database sizes will grow requiring more storage space. During the transition phase, payor and provider organizations will need to be able to run ICD-9 and ICD-10 simultaneously.

Due to the greater level of specificity, ICD-10 will allow payors to benefit in several areas:

- Higher level of detail will allow payors to get more specific and historical claim data.
- Improving coding accuracy and allow for easier fraud detection.
- Assist in case management and medical policy.

For providers, ICD-10 will give them opportunities to better leverage electronic health records and convert their clinical documentation into codes using computer-assisted coding. ICD-10 code set structure utilizes consistent logic and terminology allowing for computer-assisted coding software.

Providers will have to spend more time re-training their staff such as coders and clinicians. The new ICD-10 code sets will increase reporting requirements and during transition, providers will experience higher denial rates.

The ICD-10 implementation will be the vastest change in the US healthcare system. The coding system conversion will impact not just reimbursements but areas such as research and marketing that all depend on healthcare data. The sooner payor and provider organizations can assess their needs in regards to ICD-10, the sooner they can plan for extra resources to streamline the transition.

“The Department of Health and Human Services (HHS) extended its ICD-10 implementation deadline by two years, from October 1, 2011 to October 1, 2013, giving payors and provider organizations additional time to prepare for the transition.”

INDUSTRY NEWS



NEWS BRIEFS

RAC Updates

CGI, Region B RAC adds new DRG validation issues and removes Medically Unlikely Edits (MUEs) from list of approved issues posted on its website.

DCS, Region A RAC also added DRG issues in January and also Ambulance Unbundle Services issue.

Health Data Insights (HDI) posted the most issues in January with posting almost 70 percent of all DRGs as approved issues on its website.

CMS Issues New RAC Documentation Limits

CMS has issued the following as of January 28, 2010. In response to feedback from the RACs, providers and suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program in FY 2010 for institutional providers. These limits will be set by each RAC (CMS) on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit (defined below) may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior fiscal year Medicare claims volume.

1. Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located. Using TINs will reduce the total number of limits that would have been imposed per organization under the previous draft policy, which was based on National Provider Identifiers, while factoring in ZIP codes will promote equitability for regional or national organizations.

2. Limits will be set at 1% of all claims submitted for the previous calendar year (2008), divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services

3. Two caps will exist in FY 2010: Through March 2010, the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers. However, from April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per TIN, across all claims processing contractors) will have a cap of 300 additional documentation requests per campus unit, per 45 days.

4. In addition, in FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.

"In response to feedback from the RACs, providers and suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program in FY 2010 for institutional providers."

MESSAGE FROM OUR CEO



BY MARK EARLES, CEO

Dear Colleague –

It is with great pleasure that I find myself communicating with you again on behalf of Context⁴ Healthcare. In the 20+ years since Context was originally founded, we have undergone a number of transitions and transformations, collaborating with industry leaders and responding to the changing needs of the marketplace. And yet, throughout, we have maintained our commitment to delivering superior products and solutions – backed by expert staff – to address complex medical coding, claims editing and reimbursement challenges.

Now, in 2010, we're delighted to be able to once again support your needs as *Context⁴ Healthcare*, delivering exceptional solutions designed to strengthen your revenue stream and lower the overall cost of healthcare.

We recognize that coding and billing, combined with adjudication and reimbursement, represent two ends of the healthcare revenue cycle. Our mission is to develop highly usable, highly effective solutions that enable healthcare payors and providers alike to reduce coding and billing errors, claim denials, resubmissions, write-offs, and claim handling costs – objectives that both sides of the market have in common.

I invite you to take a few minutes to read through this newsletter, visit our [Web site](#) and reacquaint yourself with Context. We continue to dedicate ourselves to quality and responsiveness – and to helping you meet your bottom-line objectives.

Top 10 Payor Predictions For 2010

In a report titled "U.S. Healthcare Payer 2010 Top 10 Predictions," IDC Health Insights researchers list their top 10 Payor predictions:

Business Intelligence (BI) technology will be the number one investment for Payors.

Actionable advice initiatives will lead healthcare payer business intelligence priorities and investment.

Legislative and regulatory compliance initiatives will be among the top technology investment.

Payors will seek and prioritize strategic technology partnerships.

Top 10 Payor Predictions For 2010 (continued)

Segmentation will become the new strategic asset.

Reform and the value-based health plan model will drive sales and customer acquisition automations.

Payment reform will drive new investment in provider network, contract, payment, and analytic solutions.

Communications and document management technology investments.

Medical home best practices will emerge.

The report also names the healthcare reform bill and the ICD-10 mandate as the top two issues expected to affect Payors in 2010.

PRODUCT NEWS AND UPDATES



CodeLink[®]

- For Windows, CD media contains both the installation guide and the user manual in the Docs folder. The user manual is also installed to the CodeLink folder.
- For Windows, updates have all past updates included. If an update was missed, applying the latest update is all that needs to be run.
- For Windows, the update CD will perform a new install, but is missing the customer specific license file. If a PC is being replaced with a new PC, the Update CD can be used to install CodeLink, then the License file can either copied from the old PC, or if not available, a new copy can be emailed.
- UNIX, AIX and Linux, the update Media contains the current and previous updates for everything. Note: With the exception of the March update, the linkage libraries are not included in the update.

ClaimsEditor[®] Professional

- The current installer for Claims Editor Pro, on Windows will not work on Vista or Windows 7. An updated installer is in development (release date not yet set).
- Error messages that have either 1303 or 1304 are folder permission errors from Microsoft. Users need, at minimum, modify permissions on the CodeLink[®] folders and files.
- The update CD includes all previous updates. If an update was missed, applying the latest update is all that needs to be run.
- The CD does not auto start the setup. Also, due to local PC settings and /or Windows security updates, there may not be a window that pops up when the CD is inserted.



Website/Links



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