A Publication of the Quillen EHR Team

April 2013

Quillen Quick Notes

Quillen Quick Notes

Allscripts Upgrade to 11.4 — Enhancements

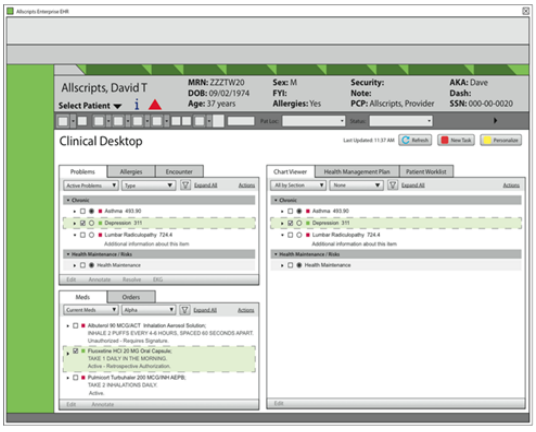
We continue to prepare for the next upgrade to the Allscripts EHR system. The next stage is important for meeting Meaningful Use requirements and ICD-10 compliance. *(See page 7 of this issue of* Quillen Quick Notes *for more information.)*

Presently, the EHR Team has been preparing for the upgrade by actually mapping the codes. This is a manual process, and it is taking several weeks to complete. Following mapping, the actual build can start taking place.

As with other upgrades, the system build has to be completed and thoroughly tested before roll-out.

Clinical Desktop

We will be seeing a different look in the system as well. The screenshot below displays a few changes. For example, the **Problem** component has been made consistent across workspaces. The look and feel and most of



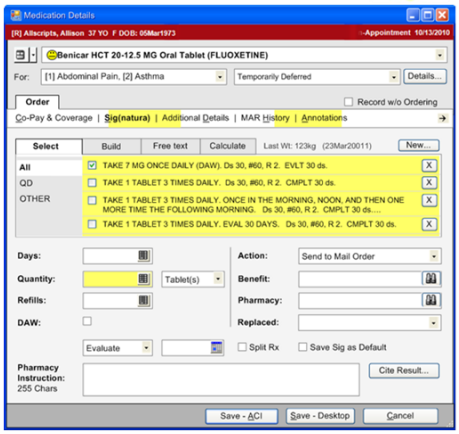
the functionality is the same whether you are in the **Add Clinical Item** workspace, the **Clinical Desktop**, or other workspaces. **Quick Filters** enable you to display or hide ICD-9 or ICD-10 codes.

Other enhancements to the system that have been anticipated:

- A Medication Flowsheet
- Patient Education Flowsheet
- New Growth Charts for Preemies and Down Syndrome (Yes, Dr. Mills, you are reading this correctly!)
- Alerts that will indicate a specific person is editing an item or note before you start documenting.

Medication Details

The screenshot below demonstrates the different look we will see for the **Medication Details** screen. The layout is more user friendly, which should make prescribing faster.



We will be sharing more enhancements as they become available to us. As soon as a date is set for the upgrade, then we will begin scheduling training and education for each of our sites and their users. Stay tuned…

Inside this issue:

Allscripts Upgrade 11.4 1

EHR Challenge
EHR Web Site
Summit Award Winners 2

Focus on...
Lab Orders 3

Help Desk Support

EHR ROCKZ 4

JCFM — Two Years
Documenting a CSMD Check 5

Documenting a CSMD Check (continued) 6

ICD-10 Myth and Fact 7

Tips and Tricks: Screening Codes for Diagnostics 8

EHR Challenge

Pizza Party Winner

A BIG congratulations to Johnson City Family Medicine for winning last month's challenge. The office will be receiving a pizza party for the highest percentage of documented smoking status.

We would also like to recognize the following Physicians and their teams for having **100%** of their patients with smoking status documented:

Infectious Disease
Jonathan Moorman
Waseem Ahmad

OB/GYN
Ann Rouse
Selman Welt

Surgery
William Browder
Joseph Lee

Cardiology
Kais Albalbissi

Pediatrics
Todd Aiken
Gayatri Jaishankar
Demetrio Macariola
Ricky Mohon
Dawn Tuell

Johnson City Family
Thomas Avonda
Joe Florence
Diana Heiman

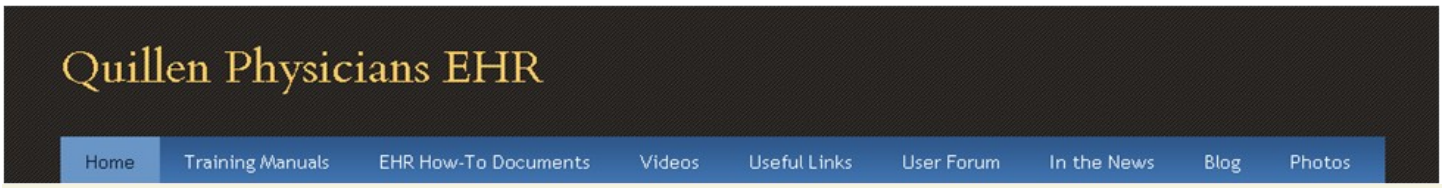
Bristol Family
Fraser Tudiver
Patricia Conner

Our team challenges will be awarded quarterly. The next challenge will be Patient Education.

April Challenge

When ordering labs, what ICD-9 code should NOT be used as a diagnosis code?

Task your answer to the Allscripts Help Team. This month's individual challenge will be awarded by random drawing from all correctly submitted answers.



The Quillen Physicians EHR website is a tremendous resource at your fingertips.

You can easily access Training Manuals, How-To Documents, Training Videos, and more.

http://quillenphysiciansehr.weebly.com/

Summit Award Winners — 2nd Quarter 2012

"Dear EHR Team and Barbara Love:

This letter is in regards to a **Summit Award** (2nd quarter 2012) nomination submitted in **December**. The **E.H.R. Team and Barbara Love** have been chosen to receive this quarter's Summit Award. Congratulations to those staff members who put forth an exemplary team-effort in responding to the needs of MEAC.

For winning the Summit Award, those employees will receive a complimentary party ($500.00 maximum), a t-shirt, and a traveling trophy to display in the work area." — *Quillen ETSU Adminstration*

"We are so pleased to have been nominated for a **Summit Award**. We truly appreciate the recognition and appreciation. Thank you so much."— *The Team*

Focus on ... Lab Orders

"Houston, we have a problem."

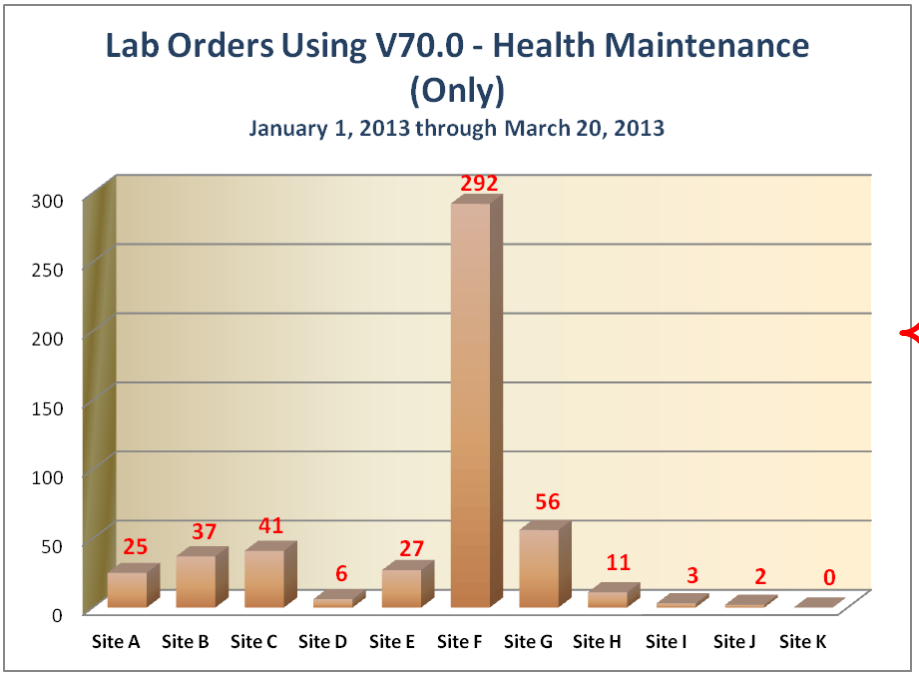
John Swigert, Jr. and James Lovell, who, with Fred Haise Jr., made up the crew of the US's Apollo 13 moon flight, reported a problem back to their base in Houston on April 14th , 1970. "Houston, we have a problem" is often credited to the project's leader , Lovell.

"QETSU Physicians, we have a problem."

Another sort of problem has been detected within our processes—a problem that affects costs to patients and clinics. The problem surfaces whenever lab orders are placed without linking to the appropriate diagnosis code or codes. One of the most common errors is linking a lab order to **Health Maintenance (V70.0).**

Please **DO NOT** use **V70.0** when ordering labs!

Data was recently extracted revealing just how many lab orders have been placed since January 2013 using only the V70.0 code as the diagnosis. These are not usually covered by insurance carriers, and the cost has to be recovered. For codes that *are* covered, take a look at last month's issue of *Quillen Quick Notes* or visit our website *quillenphysiciansehr.weebly.com.*



This graph shows how many individual lab orders were placed since January using the wrong diagnosis code. The numbers range from zero for one location all the way up to 292 orders for the location with the most improper orders.

Administrators, please contact the EHR Team to find out your individual status. We can even tell you which physician each order was placed under.

Please help us improve this!

HELP DESK

The Help Desk is available Monday through Friday, 7:30 am until 6:00 pm.

When contacting the **Help Desk,** consider the nature of support needed. **For urgent needs** (such as inability to log in or perform your job duties), **Call 282-6122 (option 1).**

For non-urgent requests, select from the following:

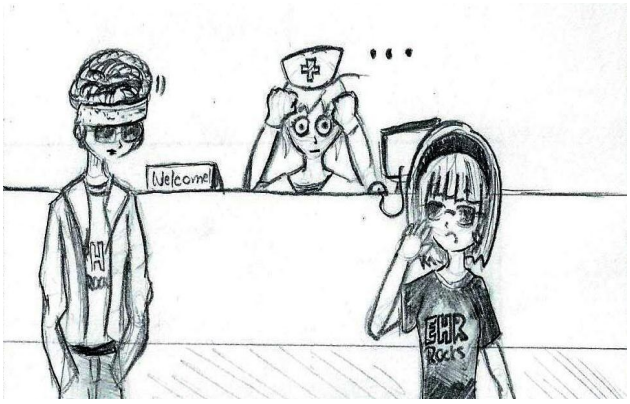
- **Task** the **Allscripts Help Team**
- **E-mail: EHRhelp@qetsu.org**
- **Open a Help Desk Ticket** by clicking on the QITS Help Desk icon on your desktop.

After-hours support is very limited. If you should have an urgent need, send an e-mail with a return phone number to EHRhelp@qetsu.org. Should a member of the EHR Support Team be available, someone will get back in touch with you as soon as possible. Please note that messages left on voicemail after hours will not reach us until the next work day.

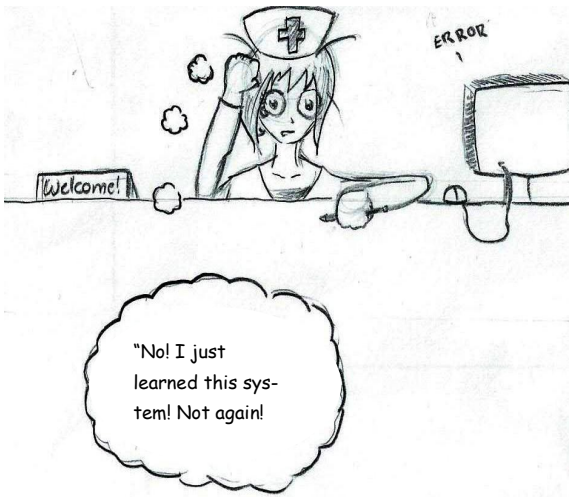
EHR ROCKZ

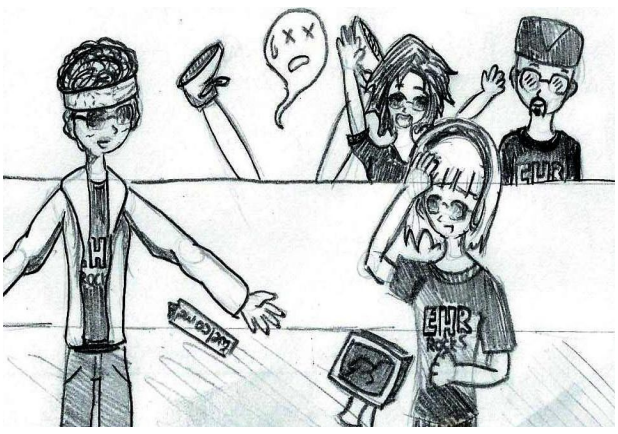
April 2013

"Have you heard the news? Rusty has decided to change EHR systems. No more Allscripts!"



"Do you mean providers , staff , and nurses will need to learn a whole new system?"





"April Fools!"

Johnson City Family Medicine — Two-Year Anniversary

There have been many changes to the EHR system since April 4, 2011—the day that the very first ETSU clinic went live with the EHR System—**Johnson City Family Medicine (JCFM).**

JCFM was the brave pilot for our organization—willing to lead the way. We now have 12 live sites, but everyone's journey was made better because of the efforts put forth by the very first site.

These empty shelves have been removed, and the space is now used more productively at **JCFM.** No one seems to miss chasing all those paper charts!

Documenting a CSMD Check in Allscripts

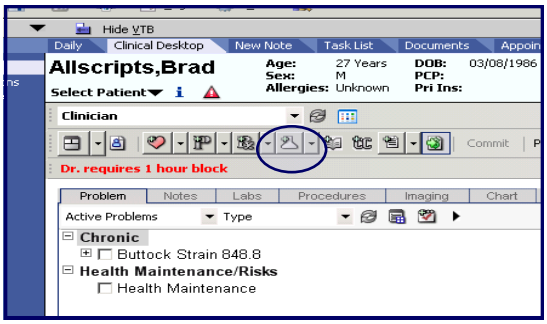
Beginning April 1, 2013, licensed healthcare providers or their designated extenders will need to check the Tennessee CSMD (controlled-substance medication database) before prescribing a controlled substance.*

It is recommended that providers document their access to the database in the patient's record, but they SHOULD NOT keep a copy of the report in the record.

In order to meet this requirement, Quillen Allscripts users can use the following workflow for proper documentation:

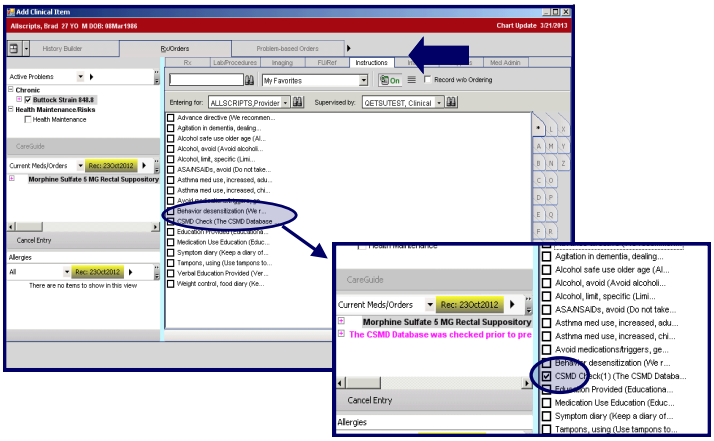
Step One

After accessing the CSMD, document that you have checked it by going to the **Add Clinical Item (ACI)** screen. Access the ACI from the patient's Clinical Desktop by clicking on the **Lab Beaker** icon or, from within the Note, click **'New'** from any Order menu.



Step Two

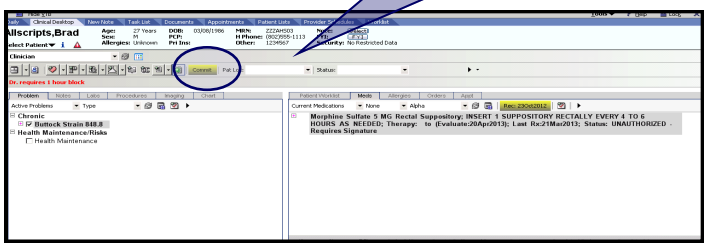
Click on the **Instructions** tab and either search for CSMD or locate it on your Quick List if it has been added to it (Recommended). Click the box next to **CSMD Check**. Once checked, the CSMD selection will appear in pink under the Current Meds/Orders.



Step Three

If you prefer to go ahead and order your medication while in the ACI, click over to the **Rx tab** and prescribe it as usual. Remember, Controlled Substance will default to Print and cannot be sent electronically. Once you have completed your ordering, make sure to **COMMIT** them.

The Med and CSMD Check can both be entered while in the ACI before Committing.



Please see the Tennessee Prescription Safety Act for specific requirements.

(continued on page 6)

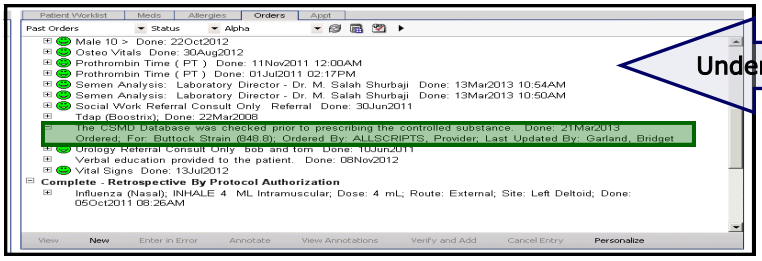
Documenting a CSMD Check in Allscripts

(continued from page 5)

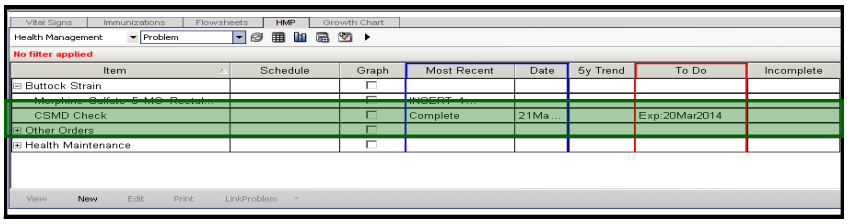
Step Four

Once the CSMD box has been checked and committed, you can locate the documentation in several places within the record.

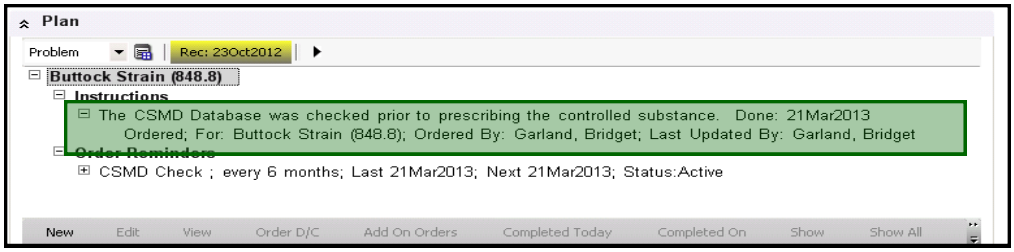
- Under the **Orders** tab> Past Orders on the Clinical Desktop.
- In the **HMP** on the Clinical Desktop.
- In the **Note** under the **Plan** section if checked.
- In the **Health Management** section of each Note.



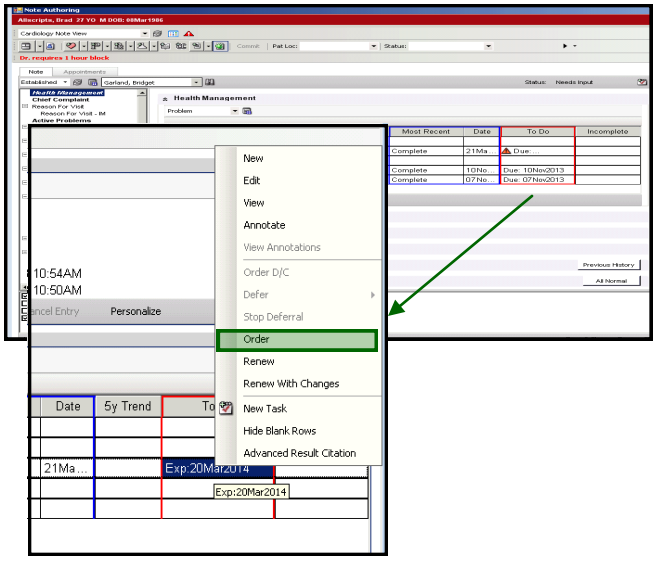
Under the Orders tab> Past Orders



In the Health Management section on the Clinical Desk-top



Under the Plan



In the Health Management section of the Note

Step Five

By default, the order is set to Expire in one year per CSMD minimum requirements for long-term treatment. Once it has expired, and the CSMD has been checked again, you can **right click** on the Expiration date under the To Do column and reorder the CSMD Check.

ICD-10 Myths and Facts

Change may be a good thing, but the process of changing can often be confusing and frustrating. Updating our current ICD-9 codes—which are over 30 years old and outdated—will be very beneficial to our nation's healthcare system, but making that switch has many people confused. The information provided below by CMS should be helpful in understanding the transition to ICD-10.

MYTH
The October 1, 2014 compliance date for implementation of ICD-10-CM/PCS should be considered a flexible date.
FACT
All Health Insurance Portability and Accountability Act (HIPAA) of 1996 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, 2014.

MYTH
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, 2014 compliance date.
FACT
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 in order to implement ICD-10-CM/PCS on October 1, 2014.

MYTH
Noncovered 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 noncovered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to noncovered entities. The Centers for Medicare & Medicaid Services (CMS) will work with noncovered entities to encourage their use of ICD-10-CM/PCS.

MYTH
State Medicaid Programs will not be required to update their systems in order to utilize 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 to find the right code. In addition, just as it isn't necessary to search the entire list of ICD-9-CM codes for the proper code, it is also not necessary to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools will continue to facilitate proper code selection. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will facilitate the development of increasingly sophisticated electronic coding tools that will assist in faster code selection. 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.

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
There will be no hard copy ICD-10-CM and ICD-10-PCS code books. When ICD-10-CM/PCS is implemented, 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
ICD-10-CM/PCS codes have been updated annually since their original development in order to keep pace with advances in medicine and technology and changes in the healthcare environment. The coding systems will continue to be updated until such time that a decision is made to "freeze" the code sets prior to implementation. For instance, the healthcare community may request that ICD-9-CM and ICD-10-CM/PCS codes not be updated on October 1, 2012 and be frozen with the October 1, 2011 updates. If the freeze is approved through formal rulemaking, it would provide a year or more of stability and an opportunity to develop coding products and training materials.

MYTH
Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.
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
Implementation of ICD-10-CM/PCS can wait until after electronic health records and other healthcare initiatives have been established.
FACT
Implementation of ICD-10-CM/PCS cannot wait for the implementation of other health care initiatives. As management of health information becomes increasingly electronic, the cost of implementing a new coding system will increase due to required systems and applications upgrades.

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: (1) Conducting a review that includes removing rarely used codes; and (2) in 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 (GEM).

MYTH
The GEMs are intended to facilitate the process of coding medical records.
FACT
Mapping is not the same as coding:
■ 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; ■ Quality measures; and
■ Payment and coverage edits; ■ A variety of research applications involving trend data.
■ Risk adjustment logic.

MYTH
Each payer will be required to develop their own mappings between ICD-9-CM and ICD-10-CM/PCS, as the GEMs that have been developed by CMS and the Centers for Disease Control and Prevention (CDC) are for Medicare use only.
FACT
The GEMs are a crosswalk tool developed by CMS and CDC for use by 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 in order 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, the condition should be coded 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.
FACT
ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will NOT affect the use of CPT.
To find additional ICD-10-CM/PCS information, including the GEMs and educational resources, visit *www.cms.gov/ICD10* on the CMS website.

Did you know...?

The 9th major revision of the ICD Coding System was adopted in 1975? It is updated annually on October 1st.

Tips and Tricks: Common Coverage Codes for Health Maintenance Screening Procedures

As we mention on page 3 of this issue, it's very important to choose the correct code when ordering labs and procedures. In last month's issue, of *Quillen Quick Notes*, we provided tips on choosing correct codes for labs. This month, we provide tips on ordering Preventative Screening Procedures.

Mammogram Screenings

Medicare covers **screening** mammography depending on the age of the woman:

You must report one of the following ICD-9-CM screening ("V") diagnosis

Age	Frequency
Younger than age 35	No Medicare payment allowed
Aged 35 – 39 years	Baseline (Medicare pays for only one screening for women in this age group)
Aged 40 and older	Annual (at least 11 months after the last covered screening mammograph

codes, listed in below for **screening** mammography:

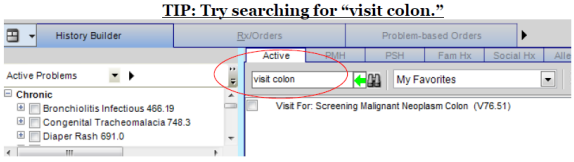
Code	Description
V76.11	Special screening for malignant neoplasms, screening mammogram for high-risk patient
V76.12	Special screening for malignant neoplasms, other screening mammogram

Colonoscopy Screening

Screening Colonoscopies are performed on patients that have NO presenting signs or symptoms related to the digestive system, but have reached the age for routine screenings (**age 50** for both men and women). Medicare covers one screening colonoscopy every 10 years for individuals not considered high risk.

Code	Description
V76.51	Special screening for malignant neoplasm, colon

TIP: Try searching for "visit colon."



High Risk Codes (Medicare provides coverage of a screening colonoscopy once every 2 years for high risk.)

Code	Description
V10.05	Personal history of malignant neoplasm, large intestine
V12.72	Personal history of colonic polyps
V16.0	Family history of malignant neoplasm, gastrointestinal tract
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

You need to **assess the actual medical necessity** behind performing the colonoscopy in the first place. It would not be medically necessary for an asymptomatic average risk patient (V76.51) to be screened at a two, three, or five-year interval. However, it might be medically necessary for an asymptomatic high-risk patient (V12.72, V16.0, etc.) to be screened every two, three or five years, therefore the diagnosis code used should reflect that.

Diagnostic Colonoscopy

When signs and symptoms are related to the GI tract (i.e., abdominal pain, blood in stool, chronic diarrhea, change in bowel habits, weight loss or blood loss anemia), **V-code (V76.51) should never be assigned**. A symptom code should be assigned when there is no definitive diagnosis. If the patient's history notes a family history or personal history of colonic malignancy or polyps, the above appropriate V- should be assigned as a secondary code.

Digestive Disease Condition ICD-9-CM Codes ICD-9-CM Code	ICD-9-CM Code Descriptor
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non infectious gastroenteritis and colitis

Pap Test

Medicare provides coverage of a screening Pap test for all female beneficiaries once every 12 months if a) there has been evidence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years or b) is considered high risk. Coverage is provided every 24 months for low risk female beneficiaries.

Diagnosis Requirements

Use one of the screening ("V") diagnosis codes listed below. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be

Diagnosis Codes	ICD-9-CM Code Descriptor
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

reported. **Failure to report the V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.**

The above information, as well as more information about other screening/preventative procedures is available by downloading The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals.