Begin to apply ICD-10 in real-life practice

By Debra Lansey

Until now, the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) codes have been mostly a theoretical construct. We’ve heard and read about them, but they hadn’t actually been applied to everyday coding situations. Now, CMS is beginning to apply ICD-10 in a more concrete manner, such as adding it to future versions of its coverage policies.

In preparation for the ICD-10 transition, CMS has revised many of its National Coverage Determination (NCD) documents by replacing the ICD-9-codes with appropriate ICD-10-codes. CMS has also instructed its claims contractors to begin updating their claim system edits with the revised diagnosis codes, to go into effect on Oct. 1, 2014.

The NCDs, one of the coverage communication tools used by the agency, are “…national policies on the coverage of specific medical services. Both the local and the national coverage processes explicitly consider whether services meet Medicare’s statutory requirements for ‘reasonable and necessary’ care,” according to a Medicare Regulations-Guidance/Guidance/Transmittals/2013-Transmittals Items/R1199O TN.html. Of the 30 revised NCDs, the following are relevant to internal medicine:

- Percutaneous transluminal angioplasty
- Cardiac output monitoring by thoracic electrical bioimpedance
- Intensive cardiac rehabilitation programs
- Diabetes outpatient self-management training
- Outpatient intravenous insulin treatment
- Histocompatibility testing

Reducing the risks of opioid management

Few things can get staff more stirred up than realizing a patient known for drug-seeking behavior is coming into the office. Establishing and closely following office procedures can help staff prepare for this difficult clinical scenario.

Each clinical and administrative staff member should have essential knowledge of chronic pain, medication safety and office policies. From front office to back, everyone should know what to do for patients with chronic pain, when to do it, and why it is important to follow the guidelines and policies of the practice.

ACP’s Medical Home Builder, online at www.medicalhomebuilder.org, addresses these issues and contains numerous resources designed to protect both the patient and the practice. The modules “Chronic Pain Management” and “Opioid Risk Management” can help a practice become consistent and confident in its treatment of patients taking long-term opioids.

Create appropriate office policies. An office policy for chronic pain management should describe the steps to be taken when patients are seen for chronic pain (both initial assessments and follow-up visits) and should include who is responsible for completing those steps, including documenting treatment. A standardized process for new patients requesting controlled substances should be included. The policy should delineate a standardized response to several common patient scenarios (such as stolen or lost prescriptions or spilt medication).

Additionally, an algorithm of care should identify patients at high risk of prescription drug misuse, overdose events or deaths. All patients experiencing chronic pain should be screened for depression. Create a practice workflow. A set of detailed office steps should be developed that describes specifically what needs to be done when patients have chronic pain check in face-to-face or via phone calls. These steps should address registration (such as how to handle outside referrals or disability forms), data collection (such as pain diagrams, functional assessment and opioid use) and triage (such as adding pain status to vital signs and functional assessments). Urine should be collected for drug testing if the patient is on controlled substances.

Adopt a medication review. This step should include checking a list of all current medications and confirming that list by requiring patients to bring in all medication containers. If the patient is on controlled substances, a pill count should be performed and documented in the chart. If possible, pharmacy records should be obtained and reviewed and a notation should be placed in the chart reflecting that the records were reviewed.

Ideally, a state Prescription Drug Monitoring Program (one example is at www.deadiversion.usdoj.gov/faq/rx_monitor.html) should be used during the review process to identify patients at high risk for prescription drug misuse, overdose events or overdose deaths. Perform comprehensive clinical assessment. The clinician should review pain and functional assessments as well as complete an opioid assessment screening. A pain history should be performed along with a supporting targeted physical examination. Staff should assist by obtaining any related medical records to be reviewed, including diagnostic tests and consultant reports/recommendations. Example assessment forms are included in the Medical Home Builder’s Resource Library. The clinician should document the specific cause of pain, if known, and assess efficacy and safety of current medication use at every visit.

Standardize controlled substance refill requests. A clear algorithm can help standardize the controlled substance prescription request process. Both the front desk staff and clinical staff should be trained to prepare and document refill requests consistently. Doing so helps meet safety and quality standards. The clinician should then review and approve or deny the prescription. Perform adherence monitoring. This involves several key processes for patients on controlled substances. The purpose of adherence monitoring is to help you detect “pseudo-addiction” (patients who are using more medication than you have prescribed because their pain is not adequately controlled) as well as abusers. Your office protocol should include face-to-face visits with revalidation no less than every 90 days, review of pharmacy data by using a state Prescription Drug Monitoring Program if one is available, pill counts and urine drug tests.

Offer resources and education. Chronic pain can be extremely difficult for the patient to cope with and may require treatment beyond medication, including multimodality treatment. Develop a portfolio of resources that you can share with your patients. These may include but are not limited to:

- Self-management education materials for chronic pain
- Exercise and conditioning classes
- Psychology, support groups,
- Acupuncture,
- Therapeutic massage and
- Chiropractic.

Next month’s CPS Tips will address how to document opioid management in the practice records.

CPS Tips is written by staff of ACP’s Center for Practice Support (CPS), a member benefit. Find CPS online at www.acponline.org/running_practice/practice_management/