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ICD-10. It's closer than it seems.

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The ICD-10 deadline is October 1, 2014.

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification / Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding

About ICD-10

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

Who Needs to Transition

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

Health care providers, payers, clearinghouses, and billing services must be prepared to comply with the transition to ICD-10, which means:

- All electronic transactions must use Version 5010 standards, which have been required since January 1, 2012. Unlike the older Version 4010/4010A standards, Version 5010 accommodates ICD-10 codes.
- ICD-10 diagnosis codes must be used for all health care services provided in the U.S., and ICD-10 procedure codes must be used for all hospital inpatient procedures. Claims with ICD-9 codes for services provided on or after the compliance deadline cannot be paid.

Transitioning to ICD-10

It is important to prepare now for the ICD-10 transition. How will ICD-10 affect your people and processes? To find out, ask all staff members how/where they use/see ICD-9.

If you haven't done so already, develop an implementation strategy that includes an assessment of the impact on your organization, a detailed timeline, and budget. Check with your billing service, clearinghouse, or practice management software vendor about their compliance plans. Providers who handle billing and software development internally should plan for medical records/coding, clinical, IT, and finance staff to coordinate on ICD-10 transition efforts.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website www.cms.gov/ICD10 for the latest news and resources developed by CMS to help you prepare for the October 1, 2014, deadline.

Information gathered from www.cms.gov/ICD10

Contents

Primary and Secondary Prevention of Cardiovascular Disease: Aspirin 81 mg versus Aspirin 325 mg

Currently, cardiovascular disease is the number one cause of morbidity and mortality in the world. The disruption of an atherosclerotic plaque can increase platelet aggregation and eventually form a blood clot that can cause a cardiovascular event, for example a myocardial infarction or a stroke. A drug with anti-platelet effects, such as aspirin, has a substantial impact on morbidity and mortality in patients with cardiovascular disease.

Aspirin is commonly used for primary and secondary prevention of cardiovascular disease. However, there is uncertainty as to whether aspirin 81 mg (low-dose) or aspirin 325 mg should be used. Aspirin is both an anti-platelet and anti-inflammatory agent due to its mechanism of action. It exerts its effect by inhibiting COX1, an enzyme involved in platelet function, and COX2, an enzyme involved in the inflammatory response. As a result of COX1 inhibition, a side effect of aspirin is gastrointestinal mucosal damage, including ulcers and bleeding. Symptoms of damage consist of gastrointestinal distress and blood in the stool. Gastrointestinal damage is a dose related side effect which can lead to the discontinuation of the medication. Therefore, in order to minimize the bleeding risk associated with this drug and effectively provide prophylaxis from a cardiovascular event, a once daily low-dose aspirin can be given because it is enough to inhibit COX1 dependent platelet function.

For primary prevention of cardiovascular disease, the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (CHEST) recommend low-dose aspirin 75-100 mg daily over no aspirin therapy for persons aged 50 years or older without symptomatic cardiovascular disease. Still, the risk versus benefit of long-term aspirin therapy needs to be considered for each individual patient. For individuals at a high risk of future cardiac events, due to the presence of significant risk factors such as hypertension, diabetes, hyperlipidemia, tobacco use, physical inactivity, and obesity, then prophylactic aspirin should be considered, but weighed against the risk of potential complications. On the other hand, the risk of gastrointestinal side effects may outweigh the benefits of aspirin therapy in low risk patients.

The advantage of long-term aspirin therapy is more pronounced in secondary prevention of cardiovascular disease. The CHEST guidelines recommend long-term single anti-platelet therapy with aspirin 75-100 mg daily or clopidogrel 75 mg daily over no anti-platelet therapy for patients with established coronary artery disease. The guidelines also suggest single therapy over dual anti-platelet therapy with aspirin plus clopidogrel. Coronary artery disease is defined as patients one year post-acute coronary syndrome, with prior revascularization, coronary stenoses greater than fifty percent by coronary angiogram, and/or evidence for cardiac ischemia on diagnostic testing.

Overall, the CHEST guidelines recommend low-dose aspirin for both primary and secondary prevention of cardiovascular disease. Low-dose aspirin is an anti-platelet agent that has been shown to effectively decrease fatal and nonfatal cardiovascular events, mainly in secondary prevention. However, before any patient is started on low-dose aspirin, a risk versus benefit analysis should be performed, especially in primary prevention.

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THE POWER OF WORDS

("I Don't" Beats "I Can't")

Dr. Karla Kay Potetz
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"Watch your mouth!" Most of us have heard those three words throughout our lives and on a variety of occasions. It was one of my parent's favorite responses to me when as a child I vigorously registered my discontent with what I perceived to be an unfair situation. Dr. Phil often tells teenagers to watch their mouth when they get 'snarky' with him. We pay attorneys large amounts of money to function as our 'mouth piece' because we fear saying the wrong thing.

But let's examine watch your mouth from another perspective. What about personal declarations? How many of us have lamented "I should have said_____," when things didn't turn out the way we wanted? We irritatingly bellow, "I told her I couldn't go, but she kept nagging me. Why don't people listen to me? I said I couldn't."

Why is it that when we say one thing, people hear another? We understand the concept of selective hearing and realize that people hear what they want to hear, but in this case, you specifically said you couldn't. That's very specific, isn't it? This is where 'I don't versus I can't' come in to play.

In four different studies in the August 2012 Journal of Consumer Research, researchers examined the effect wording has on our success with personal declarations. For example, in an attempt to lose a few pounds you decide to refrain from eating sweets and you're quite successful. Then the weekend arrives and you're out to lunch with a friend. After the meal she says, "Let's get dessert," and your response is, "I can't eat sweets right now. I'm trying to lose a few pounds." She says, "Come on, it's the weekend. A little ice cream isn't going to make a difference one way or the other; and I can't eat dessert alone." So you reluctantly eat dessert, feel guilty and then blame your friend for talking you into it. "Why can't people just accept what I say," you ask yourself. "I was doing fine on my diet until I had lunch with her."

While reading this article you might be thinking about willpower and how if it had been applied could have helped in this situation. We know that self-discipline and will power come into play whenever we're trying to resist temptation. 'It's not what you said, but how you said it' comes to mind as I review this article. Now that I think about it, I frequently heard that phrase as a youngster as well. Researchers have examined the effect of different wording when using self-talk to resist temptation. When participants framed a refusal as "I don't" (for instance, "I don't eat sugar or sweets") instead of "I can't," they were more successful at resisting the desire to eat unhealthy foods.

Vanessa Patrick, professor of marketing at the University Of Houston C. T. Bauer College Of Business, says, "I believe that an effective route to self-regulation is by managing one's desire for the temptation, instead of relying solely on willpower." She also believes that deprivation is an ineffective route to self-control because I can't connotes deprivation which of course increases our desire for that which we feel deprived. Think about it. When we feel deprived, we really want whatever it is that we cannot have. It goes around and around in our mind until we give in and do whatever we said we couldn't have or do.

I don't on the other hand is quite declarative, and expressing ourselves with simple declarative sentences helps clarify meaning to us and others. "I don't eat sugar and other sweets," sounds definite. "I can't eat sugar and other sweets," implies that with a little encouragement we might be able to do whatever it is we're talking about. I can't invites an "Of course you can" from well-meaning friends. It implies that with a little persuasion you'll be able to conquer the I can't.

If you want to act powerfully, you must master the power of words. The word can't implies that you lack the ability to do something. Using the word won't implies that you've made a decision and therefore will not do something. Eating dessert or not eating dessert does not suggest an inability; it is in fact a choice.

Less successful folks substitute I can't for I won't because it seems to let them off the hook. Because the activity is something they can't do, they can't reasonably be expected to do it. Though this distinction seems pretty clear, many of us fail to grasp the true meaning. For example:

- I'm too heavy but I can't lose weight.
- I can't walk very far; therefore I can't exercise.

By contrast, winners, or successful people are more precise. They use I can't as a signal that they need to develop or improve a skill, and they use I won't as a statement that they've made a decision. For example:

- I can't seem to lose weight so I'll adjust my diet. I won't eat sugar and sweets.
- I can't walk very far. Therefore after dinner I won't sit in front of the TV, I'll go outside and walk a small amount every evening. That way I can build my stamina.

By using I can't and I won't appropriately, winners take responsibility for their actions rather than making excuses. That's a major reason they're so successful.

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Systems Based Approach to a Quality Care Environment

by SM Cleveland, BSN, RN Director of Nursing Services

The Centers for Medicare and Medicaid Services (CMS) Department of Health and Human Services issued a memorandum in December 2012 addressing the Nursing Home Quality Assurance & Performance Improvement (QAPI) guide. This guide is detailed to enable nursing homes to understand QAPI principles to begin incorporating these principles into their systems of care by July 1, 2013.

So what is QAPI? It is the merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI). These approaches differ in the way they seek and utilize information.

QA is a process of meeting quality standards and assuring that care meets an acceptable level.

PI is a pro-active and continuous study of processes with the intent of preventing or decreasing the likelihood of problems by identifying opportunities and testing new approaches to fix the underlying causes.

Once established, people report it as a rewarding and enjoyable way of working. Rewards such as ability to solve quality problems and prevent recurrence; ability to seize opportunities to achieve new goals; caregivers become active partners in PI and overall better care and better quality of life for residents.

Using the five elements framework, your facility may undergo a culture change. This requires a possible paradigm shift in Leadership responsibility and accountability, the development of a deliberate approach to teamwork, a whole house 'self-assessment', identified organizational principles, a QAPI plan, communication campaigns, data collection and usage strategies, gap and opportunity identification, prioritization, a definitive problem solving model, dedication to root cause discovery, and a systematic approach to action. Also bravery, don't be afraid to try new things or re-try old things in a new way.

For further information visit CMS website http://go.cms.gov/Nhqapi