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## Getting ready for ICD-10 by 2013

**ICD-9 is more than 30 years old and outdated. Its successor will reflect advances in medicine and be a boon to research and public health, -- but the transition will be a burden for physicians**

ICD-10 is slated to succeed ICD-9 effective October 1, 2013, as the HIPAA-required system for coding diagnoses in all clinical settings and for hospitals to report inpatient procedures. (CPT will remain the coding system that doctors use to report services and procedures, regardless of setting.)

The U.S. Department of Health and Human Services (HHS) is mandating the change because ICD-10 better reflects current medical knowledge and technology and also permits greater specificity in coding and reporting diagnoses and procedures. Consequently, ICD-10 will provide a more consistent and logical framework and yield better data to support public health surveillance and research.

The differences between ICD-9 and ICD-10 are substantial, and therefore the transition is certain to be burdensome for

physicians. Practice management staff and physicians should begin taking steps now to prepare for the October 2013 compliance date.

### AMA and RIMS advocacy

HHS initially called for a much tighter compliance date of October 1, 2011, for nationwide implementation of ICD-10. In 2008, RIMS joined the AMA and other medical organizations in calling for a revision of that timetable. The physician groups argued that CMS underestimated the time and expense involved in retraining and retooling from a system of about 16,000 procedure and diagnosis codes to a new system of 155,000 codes. In January 2009, HHS relented, pushing the deadline back by two years to October 1, 2013.

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## Liability notes: Rhode Island and the federal "demonstration projects"

When U.S. Senator Sheldon Whitehouse addressed the RIMS Council on August 17, 2009, physician members of the Council repeatedly expressed their disappointment and incredulity that health system reform efforts in Washington allegedly aimed to control costs but were perversely ignoring a major driver of unproductive expense in American health care: liability and defensive medicine.

Three weeks later, in his September 9, 2009, address to a joint session of Congress, President Obama announced a

new federal program of liability "demonstration projects," the purpose of which would be to identify and measure effective strategies to improve the liability system in ways that would better serve patients, reassure doctors and save the system money as a result.

Presidential recognition that the liability system might be a major part of the problem was encouraging. Add the promise of a new opportunity, supported with government funding, to demonstrate better models, and the message was more encouraging still. Yet one had to reflect:

we already have lots of data on what works and does not work in liability. For example, California's successful "demonstration project" has been running for 34 years. Many other states have long been "laboratories of democracy" for testing various kinds of liability reforms.

Nevertheless, the health care community can hardly fail to respond to the President's challenge and must seek to make the most of it.

Accordingly, on September 10, 2009, the Rhode Island Medical Society (RIMS) and the Hospital *continued page 7*

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## Federal demonstration projects – continued

Association of Rhode Island (HARI) and Quality Partners of Rhode Island (QPRI) began working together to prepare for the Washington rollout of the specifics of the Obama Administration's newly announced program. It was quickly apparent that Rhode Island would have plenty of material to work with in making a case for a demonstration project, or at least for a planning grant. For one thing, the state is close to being a *tabula rasa* for liability reform, and therefore the results of any experiment would be complicated by fewer variables. In addition, groups in Rhode Island had recently put in huge amounts of highly sophisticated and successful work in such areas as ICU safety, wrong-site surgery, the medical home model, e-prescribing, HIT and others.

When the U.S. Department of Health and Human Services (HHS) released the parameters of the administration's plan, it was unclear whether organizations like RIMS, HARI or QPRI could actually qualify to apply for the new federal funds. (The pot of funding, it turned out, would amount to only \$25 million nationwide, for which the competition is likely to be fierce.) Direct discussions with HHS clarified that neither RIMS, nor HARI nor QPRI was eligible to apply for the program. Indeed, only an integrated health system or an agency of state government would be eligible.

RIMS, HARI and QPRI therefore next approached the Rhode Island Department of Health and offered to perform the work of applying for the funding and of executing the project if the Department would only sponsor the effort and lend its name to it. The Department declined, credibly citing its acute lack of resources.

Meanwhile, Mary Cooper, MD, JD, a Lifespan Vice President, was on a similar quest. Lifespan itself, with its member hospitals and its captive liability insurer (Rhode Island Sound Enterprise, or RISE), has all the attributes and components to be a credible applicant. Moreover, Dr. Cooper has close, personal connections with colleagues in New York and Colorado with whom she quickly designed a creative proposal for a three-state demonstration project she dubbed "ON BASE": Operating under New Boundaries for Adverse and Serious Safety Events.

ON BASE proposes to focus on five areas of patient safety: bloodstream infections; wrong-site surgery; retained foreign object; pressure ulcers; and venous thrombo-embolic events. Dr. Cooper envisions informing patient expectations through a redesigned informed consent process; decreasing the incidence of the five kinds of adverse events by drawing on best practices; implementing disclosure and apology when such events do occur; and mitigating losses in part by moving toward a model that emulates worker's compensation.

RIMS, HARI and the AMA have endorsed ON BASE. The application deadline was January 21, 2010. ❖



Michael Migliori, MD appeared on a special edition of Channel 10 Newsmakers discussing health system reform with WJAR health reporter Barbara Morse Silva (right) and public policy analyst Stacy Paterno (left).

## MinuteClinic™ moving its headquarters from Minnesota to Woonsocket

MinuteClinic, the company that started placing health care kiosks in big box stores, supermarkets and drug stores ten years ago, was acquired by CVS Caremark of Woonsocket, RI, in 2006. In November 2009, it was announced that MinuteClinic would move its corporate headquarters from Minneapolis to Woonsocket in order to be closer to its parent. The move eliminates 150 jobs in Minneapolis but raises hopes that a similar number may be created in Woonsocket.

The move "supports our goal of tighter integration of MinuteClinic with CVS Caremark," CVS spokeswoman Carolyn Castel told the media. It also will "foster better alignment with CVS Caremark's chronic care, patient engagement and disease management initiatives."

MinuteClinic is the largest chain of retail-based clinics in the country with 500 outlets. Just one of those clinics operates in Rhode Island; it is located inside CVS Caremark's corporate headquarters. (Walgreens' TakeCare is the second largest chain of retail-based clinics with about 350 outlets.)

CVS Caremark operates the largest network of retail pharmacy stores in the nation, with more than 7,000 outlets in 43 states. ❖