

THE LEADING EDGE

WINTER 2015 ISSUE

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THE LEADING EDGE

Welcome!

We start 2015 off with several important topics and trends. First is an update on ASC billing and code changes for 2015.

Next we peer into our crystal ball to find the “Top 5” Trends for 2015: we hope you find them interesting and thought provoking. If we missed something important, please let me know!

With ICD-10 scheduled for October of 2015, it’s time to dust off plans and get the implementation efforts going. We review the debate about additional delays and outline the steps that need to be taken now. We also continue our series of ICD-9/ICD-10 comparisons.

Our next feature describes “reference pricing.” Sometimes called a “reverse deductible,” reference pricing is used for scheduled, higher ticket items like knee replacements and colonoscopies. The insurer sets a price—the reference price—and pays the amount charged, up to that amount. The patient pays everything else. As with most experiments, there are pros and cons.

Most forms of payment reform such as ACO’s, bundled payments and “shared savings” transfer financial risk from the insurer to providers. In the next feature article, we highlight this inevitable trend and insights about what it means. For many physicians and hospitals, it is uncharted water: e.g., thinking about “population health.”

Finally, we highlight target areas in the OIG workplan that could affect ASC’s in 2015.

Note that there is now a PDF “button” in the right sidebar to download the entire newsletter for email or printing.

As always, we appreciate your feedback and suggestions. Please call or email me with comments and suggested topics for the next issue: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

ASC Billing and Code Changes for 2015

At the end of October, CMS released its final 2015 ASC payment rule and in November the 2015 CPT® Manuals were released containing the new, deleted and revised CPT® and Category I and II billing codes.

ASCs were given a 1.4 percent increase (up from 1.2 percent increase in the proposed rule) in Medicare payments, based on a 1.9 percent adjustment to the consumer price index, minus a 0.5 percent productivity adjustment. However, CMS continued to use the Consumer Price Index for All Urban Consumers (CPI-U) to update ASC rates instead of using the Hospital Market Basket cost measures, which in 2015 will increase hospital payments by 2.2 percent.

The ruling finalized 10 spine procedures added to the ASC list of payable services and added an additional CPT® code (63044) to the list. CMS recognized that CPT codes 22551, 22554, and 22612 were assigned to the wrong ambulatory payment classification (APC 0208). The final rule moved these codes to APC 0425, which has a higher reimbursement. An esophageal reflux test was also added as payable in the ASC setting in 2015. The new codes are:

- 22551 – Neck Spine fuse & remove bel c2
- 22554 – Neck spine fusion
- 22612 – Lumbar spine fusion
- 22614 – Spine fusion extra segment
- 63020 – Neck spine disk surgery
- 63030 – Low back disk surgery
- 63042 – Laminotomy, single lumbar
- 63044 – Laminotomy, additional lumbar
- 63045 – Removal of spinal lamina – cervical
- 63047 – Removal of spinal lamina – lumbar
- 63056 – Depress spinal cord
- 91035 –Esophagus, gastroesophageal reflux test with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation

There have been many other changes in the CPT and Category I and II codes for 2015 that affect ASCs.

There are:

- 44 New CPT® codes for 2015
- 24 New Category I and Category II Codes

- 50 Deleted/Discontinues CPT codes
- 29 Deleted/Discontinued Category I and II Codes

The Ambulatory Surgery Center Association (ASCA) has added resources to their website listing all the code changes with an objective to assist ASC operators in determining the impact of the 2015 Medicare changes. The information is available to ASCA members and to non-ASCA guest members, who must obtain a password to view the information. Click on any of the following ASCA resources and instructions for login will be provided.

- [Newly device intensive codes for 2015](#)
- [Newly packaged codes for 2015](#)
- [Newly added and deleted codes for 2015](#)
- [Medicare Rate Calculator](#)

You may also visit ASCA's [Medicare Payments Resources webpage](#) to access their available payment documents.

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Top 5 Trends for 2015

The beginning of a new year is always a good time to look ahead. From our crystal ball, here are the trends likely to shape 2015:

- ICD-10
- Value-based reimbursement: PQRS, VBM and more
- HIPAA Security
- Evolving patient payment models
- Price transparency

At the end of the article, we've included a bonus: 3 trends that are "on the horizon."

ICD-10

As we discuss [elsewhere in this issue](#), now is the time for physicians and hospitals to make sure ICD-10 implementation plans and actions are in place. Of course, there are still those lobbying to postpone ICD-10 for a third time. But we believe the political process is likely to yield a clear direction by early April, if not sooner.

The Medical Society of the State of New York, the Texas Medical Association and the National Physicians' Council for Healthcare Policy lobbied Congress to include an ICD-10 postponement to 2017 in the "Cromnibus" bill that passed Congress in mid-December (to fund the federal government for the balance of the fiscal year). But that effort was unsuccessful.

'As a result, House Rules Committee Chair Pete Sessions (R-Texas) and House Energy and Commerce Committee Chair Fred Upton (R-Mich.) issued a joint statement:

"The Energy and Commerce Committee has been working with CMS to ensure the October 1, 2015, implementation is achieved and is prepared to have a hearing on the issue in the New Year.

As we look ahead to the implementation date of ICD-10 on October 1, 2015, we will continue our close communication with the Centers for Medicare and Medicaid Services to ensure that the deadline can successfully be met by stakeholders,' said Upton and Sessions. 'This is an important milestone in the future of health care technologies, and it is essential that we understand the state of preparedness at CMS. Following the most recent delay of ICD-10, we heard from a number of interested parties concerned about falling behind or halting progress. We would like to

acknowledge and thank these organizations and individuals for opening up this dialogue and expressing their thoughts and concerns regarding this issue. It is our priority to ensure that we continue to move forward in health care technology and do so in a way that addresses the concerns of all those affected and ensure that the system works.”

The bottom line is that these hearings will listen to both sides in the debate about delaying ICD-10. Congress has to deal with the SGR issue before the end of March when the current “SGR fix” expires. Those lobbying for a delay will be doing everything possible to include it in the SGR legislation while opponents of delay will be lobbying equally hard to prevent further delay.

In the meantime, it is prudent for physicians, hospitals and their partners to continue ICD-10 preparations. AdvantEdge is fully prepared and will be reviewing plans with clients in early 2015. We have continued to publish ICD-9 to ICD-10 comparisons in this newsletter; they are all available on the AdvantEdge website for reference.

If there is no delay, those who wait on the Congressional “decision” before getting serious about ICD-10 preparation will have a lot of last minute preparations.

Value-Based Reimbursement: PQRS, VBM and More

Medicare’s move to so-called “value based reimbursement” is now entering a new phase. In the past, PQRS participation could yield an incentive payment; going forward, successful participation means no penalty. When coupled with the Value Based Modifier Program (VBM), additional penalties may accrue, or physicians may see a VBM incentive.

Unfortunately, PQRS and VBM are quite complex and require that important decisions be made now for 2015 (regarding which PQRS measures to report and how to report them). More details on the programs are available in the 2015 CPT and PQRS Update article in this newsletter.

AdvantEdge client managers will be reviewing recommended measures with clients as part of 2015 planning to assure that measures are selected and that appropriate processes are in place to submit them.

In addition, an increasing number of commercial payers are experimenting with, and adopting, similar measures. It is too early to describe trends except that these efforts are often linked to ACO and related initiatives.

Both Medicare and private payers often seem to make the assumption that a practice has an EMR in place to submit the measurement data. For groups that have an EMR, this may still be a challenge. But for hospital-based groups such as radiology, pathology and anesthesia who typically do not have an EMR, this implicit assumption means that it is time to consider registry reporting, in order to have greater confidence that penalties are avoided.

HIPAA Security

With stories in the news every day of major corporations being hacked and breached (recent examples are J.P. Morgan and Sony Pictures), the need for increased electronic security has never been more apparent. Fortunately, most health care providers are not as visible or lucrative a target as a major corporation. But that does not mean that anyone can relax. The technical and human vulnerabilities that enable a breach, whether accidental or intentional, remain all too real.

We have written before about important dimensions of HIPAA compliance, including [How to Avoid Being a Target](#). In this issue, we provide a [useful checklist](#) to help practices and hospitals assure that all the bases are covered.

One HIPAA requirement that is often overlooked is the annual “security assessment” or risk analysis. In today’s environment, not only is this required by HIPAA, it makes the utmost in common sense. Conducting a thorough security assessment may not prevent every possible breach, but it will reduce risks dramatically. Setting aside the headlines from hackers, most breaches in healthcare arise from basic mistakes: e.g. unencrypted laptops, poor record destruction procedures, etc. Electronic security can be improved through steps such as strong passwords, frequently changed passwords and/or two factor authentication.

Of course, a security assessment must look at the technical infrastructure and assure that it is as secure as possible, considering the hacking risks. But even in this area, the most common errors are administrative: e.g. who has access to servers, networks and passwords.

We all know that there is no such thing as perfect security. But we can sleep better if we know that we have minimized the risks. For any provider who has attested to Meaningful Use, there is another benefit: the most common reason for providers to fail an MU audit is the lack of an annual security assessment!

Evolving patient payment models

The past year has seen a number of changes in how consumers buy insurance, the type of insurance and their role in paying for health care. These trends are expected to mature and accelerate in 2015.

The general trend is that consumers are paying an increasing proportion of healthcare costs in the form of higher premiums, co-pays, deductibles and co-insurance. We have previously written about the advent of [Private Exchanges](#), the continued growth of [Medicare Advantage](#) and the [implications for physicians of the public exchanges](#).

Of course, the increase in premiums and cost increases in general result in behavior changes, both by consumers (see the next trend on pricing transparency) and by insurers. So-called “narrow networks” started to emerge in 2014 and more are expected in 2015 (subject to somewhat increased scrutiny by CMS). Some commercial ACO’s are designed around limited networks of providers and these are expected to increase as well.

A key part of this trend is the continuing growth in High Deductible Health Plans offered by employers and the Insurance Marketplaces (Exchanges). A study by the National Business Group on Health shows that 81% of large employers will offer at least one HDHP in 2015. Perhaps more telling, the same study indicates that one-third of large employers plan to offer only high deductible plans in 2015. While there is no similar data for smaller employers, anecdotal evidence suggests the percentages are higher.

As a result, in 2015 we should expect more and more patients with substantial deductibles and co-insurance. A recent analysis by Avalere Health shows that more Exchange plans have set their out-of-pocket limits at the statutory maximum for 2015 and that average silver plan deductibles increased by 7 percent—to nearly \$2,700[1]. The immediate impacts are on patient registration, eligibility and billing procedures. Plus there is some evidence that patients are deferring doctor visits and procedures due to higher out of pocket costs. The longer term implications are less clear, but many expect this trend to lead to greater “consumerization” of healthcare where patients shop on price and quality before choosing their providers.

Price transparency

As is evident in the previous trend, patients are paying an increasing portion of healthcare costs. Efforts have already started to make [provider costs more visible](#). But

it is clear that these efforts will gain momentum and expand in 2015.

Government initiatives such as the CMS publication of Medicare payments to physicians are expected to continue. And CMS continues to move forward to implement the ACA requirement for hospitals to publish their charges. State efforts to require price disclosure are continuing to ramp up.

But perhaps the biggest force toward transparency is coming from the private sector. Companies like CastLight have created a successful business by capturing and sharing actual provider costs. This success has not gone unnoticed and many other firms are following the same path.

Price transparency also applies to comparing health insurance premiums. Many firms have offered these services to employers for years. But with the advent of the health care exchanges, private firms are now providing information to consumers. For example, the New Jersey firm Vericred recently launched PlanCompass.com for the New Jersey individual insurance market, with plans to expand to the Northeast in January and nationwide in 2015. Their website allows consumers to see if their preferred doctors, hospitals and other health care providers are part of the plan they're looking to buy.^[2]

The biggest push to make healthcare prices visible will come, of course, from consumers. American consumers are used to making quality and price tradeoffs every day. As the costs hit consumers in the wallet, they are expecting healthcare providers to behave the way every other business does—regardless of the practical issues involved regarding how to measure quality, the differences in patient conditions, etc.

Bonus: 3 Emerging Trends

1. ACO's

ACO's are clearly not new, so what is the emerging trend for 2015? Answer: the likelihood that a practice or hospital will be impacted by one or more ACO's is increasing rapidly. With over 600 active across the country, the experimentation phase may be ending. 2015 may not be the year for ACO's to achieve critical mass, but many think that time isn't far away.

2. Meaningful Use?

Meaningful Use isn't new, so why an emerging trend for 2015? Because the era of MU

to receive government incentive payments is coming to an end at the same time that the complexity of the MU rules and pending physician and hospital penalties threaten to upset the entire program[3]. With over 250,000 providers seeing an MU-driven cut in Medicare payments in 2015[4], it seems that MU criteria changes have to be on the horizon. But at the same time, numerous other initiatives for interoperability, ease of use, etc. are ramping up. As the CMS version of MU recedes, will we see real meaningful use emerge? It's too early to tell for sure, but most physicians and other providers hope so.

3. DIY Healthcare

2014 was the year when "personal fitness devices" began to emerge in a serious way. For 2015, 18% of American adults say they will probably or definitely purchase a wearable device in the next twelve months, according to recent research conducted by Ipsos MediaCT[5].

The question is: how does the healthcare community react? Are there ways to take advantage of the coming explosion in devices and information?

One hospital trying to answer those questions is Morristown Medical Center in New Jersey. They have opened a store in the hospital's lobby named HealtheConnect modeled on Apple's "genius bar." It offers digital wellness and fitness devices plus health management apps. More importantly, it provides advice about how to use them, whether the devices are purchased in the store or elsewhere.

Dr. David Shulkin, president of Morristown Medical Center, sees advances in population health flowing from personal medical technology, like mobile phone apps that help diabetics care for themselves, and fitness-boosting wrist bands that track the number of steps we walk each day[6].

In another example, the Ochsner Health System is linking its Epic EMR to Apple's HealthKit platform. "In the past, we relied on patients to log information, bring it to us, and then we would input the data and decide a course of action," said Robert Bober, MD, Director of Cardiac Molecular Imaging, Ochsner Medical Center. "Now we can share information seamlessly between patient and physician to allow real-time, accurate analysis of a patient's health status. This is ideal for patients with chronic diseases such as heart failure, hypertension and diabetes." [7]

There are certainly others in healthcare working to take advantage of this explosion in

new technology. 2015 will be a year of experimentation and learning. Since the technology is only emerging, will the early adopters be showing the rest of us what the future looks like?

[1] HFMA Healthcare Business News, December 12, 2014. "[ACA Plans Lift Out-of-Pocket Caps.](#)"

[2] NJBiz, December 16, 2014. "[Website aims to help health insurance shoppers see who's in-network and who isn't.](#)"

[3] Modern Healthcare, December 18, 2014. "[Providers balk as CMS announces penalties for 2013 EHR issues.](#)"

[4] Medical Economics, December 18, 2014. "[Meaningful Use penalties sear more than half of EP's in 2015.](#)"

[5] Ipsos, December 8, 2014. "[One in Five \(18%\) Americans to Purchase a Wearable Device in the Next Year.](#)"

[6] NJBiz, December 17, 2014. "[Health management? There's an app for that — and Morristown hospital store will make it work for you.](#)"

[7] Ochsner Health System Newsroom, October 6, 2014. "[Ochsner Health System First Epic Client to Fully Integrate with Apple HealthKit.](#)"

Are You Ready for ICD-10?

ICD-10 is scheduled for October 1, 2015 even though some observers think another delay is possible. Congress is scheduled to hold hearings in the first quarter to assess CMS and industry readiness. Most industry participants and many physicians are prepared and strongly support moving to ICD-10, without further delay. In contrast, the AMA remains opposed.

ICD-10 has become so controversial that a “back room deal” in Congress postponed implementation from 2014 to 2015. In many ways, the controversy is surprising, given the benefits of more specific diagnosis information:

- Improved patient outcomes: e.g. diabetes has six times as many codes, to help physicians better match patients with specific programs.
- Better information for outcomes research from more detailed data mining: e.g. insight into adverse events such as falls and hospital-acquired conditions. Areas of injury research and trauma services evaluation, for example, could witness a marked improvement ..., AHIMA reports[1].
- Potential financial benefits from billing for more complex treatments associated with sicker, high-risk patients and more accurate payment for new procedures.
- After the initial growing pains subside, the added degree of specificity required for clinical documentation is also expected to result in fewer rejected claims[2].
- Over time, practices, hospitals and individual physicians will have more detailed performance data to benchmark versus their peers.

Despite these benefits, the perceived costs and risks have more attention with some physicians and politicians. The primary concerns are:

- The added costs of converting systems, training staff, etc. A widely circulated AMA study[3] in February 2014 shows significant costs, especially for smaller practices. A more recent AHIMA study[4] suggests these costs are overstated by a large amount.
- Other government mandates imposing costs and burdens on physicians and hospitals in the same timeframe. These include Meaningful Use, PQRS, Value Based

reimbursement, etc.

- Physician productivity loss from dealing with more codes.

Without a crystal ball to see if ICD-10 gets postponed again, hospitals and physicians have no choice but to be prepared. Even if you completed an assessment to prepare for 2014 implementation, it is time to update it since vendors and workflows may have changed in the past year.

It is important to remember that ICD-10 is not just a claims submission issue. Transitioning to ICD-10 affects the “clinical encounter, patient scheduling, lab and diagnostic imaging orders, pre-authorizations, clinical trials, quality reporting and other areas of a medical practice.”

This article emphasizes steps that hospitals and physician groups need to take during 2015:

- Train staff
- Train physicians
- Verify that all systems are updated
- Review payer contracts and procedures
- Financial contingency planning
- Test, test, test

Train Staff

By now, hospitals and physician groups should have a specific plan and timeline for training each employee. If not, creating the plan is an urgent priority.

ICD-10 code training should start in the first and second quarters, using the final ICD-10 codes. Training can include sending key employees to classes so they can train others, on site classrooms, webinars and Internet-based programs.

Training for coders should have already started so that, ideally, they can be certified in ICD-10 before October.

If coding is done by an outside party, it is important to review their training plan and assure that you are confident in their ability to be ready.

Train Physicians

Yes, physicians must participate in the training process. ICD-10 challenges the way many physicians document, demanding a greater level of specificity. Best practices include:

- Identify the most common 10-20 ICD-9 diagnoses and compare current documentation to ICD-10 requirements. From this analysis, documentation strengths and weaknesses are seen including areas where documentation must be changed.
- Audit current documentation to find patterns of missing information. Specialists should look carefully at referrals (orders).
- Create templates in EHR systems or paper-based templates to guide required documentation in common clinical areas.

Physicians who have coding done from dictated reports need to ask their coders if their dictation is sufficient for ICD-10.

Verify that Systems are Updated

Practice management, EMR, billing and other systems must be upgraded to store and transmit both ICD-10 and ICD-9 codes. At this point, a firm upgrade schedule should be in place for each system to complete no later than the end of the summer and preferably sooner.

Maintaining both ICD-9 and ICD-10 is critical so that claims may be submitted both before and after October 1. Practices and hospitals that participate in clinical trials or research studies will also need to have both coding systems available.

It is of utmost importance that all systems are tested well before October 1. Testing at the last minute will be risky, as there are always issues to iron out and vendors and insurance carriers are highly likely to be back-logged in the third quarter, especially September.

Make sure ICD-10 transition terms and schedules are in vendor contracts. This includes being clear about incremental costs, including testing.

Review Payer Contracts and Procedures

Insurance contract negotiations need to include ICD-10 so that services billed with ICD-9 are covered when ICD-10 is in effect, and at the same rate. In the future, carriers are expected to change their rates to be in line with more specific ICD-10 codes.

It is also critical to stay in close touch with your major payers to know which will not be ready. We saw this with 5010, where some carriers were not ready on January 1, 2012 and billing had to be via 4010 until their systems could accept 5010. If you use a billing service, this is an area they will handle on your behalf.

Financial Contingency Planning

Hospitals and physician practices must have a budget to implement ICD-10 including:

- Software modifications,
- Education for physicians, coding staff, etc.,
- Testing, and
- Potential temporary staffing to assist with increased work during the transition

Contingency planning should include a plan for possible cash flow interruptions. One common approach is a bank line of credit (LOC). Many experts recommend a reserve of 2 to 3 months of cash flow. The LOC must be established in advance of the need because it is much easier to get the LOC when the hospital or practice can demonstrate a steady cash flow than when cash is delayed. However, many LOC's have a fixed term, often 12 months. Therefore, the optimum time to establish the LOC is late summer.

Test, Test, Test

An effective ICD-10 plan must assure that the organization is ready prior to October 1. The most obvious area for testing is with systems, especially those that affect payment. Unfortunately, testing with insurance companies depends on their testing schedules. Whether your billing is done in house or by a billing service, make sure the test schedule is established and monitored.

Testing of staff and physicians may be more challenging since it can't be done too

soon but it must be done far enough in advance to correct any issues identified. One best practice is to perform “dual coding” for a select period of time: i.e. create ICD-9 codes needed for current operations and ICD-10 at the same time. While this approach is not always feasible, it will identify many issues that can be fixed before October. An ideal timeframe for dual coding is mid-summer.

Summary

Whether we personally “like” ICD-10 or not, it is a pre-requisite for many advancements in healthcare. But these longer term benefits come with short-term costs that must be addressed now. This article has outlined the major steps that hospitals and physicians need to take in 2015 to successfully implement ICD-10 on October 1. While some issues are sure to arise, organizations who take these steps will find the transition much easier than those who do not prepare adequately.

[1] Physicians Practice, October 2013. “The Benefits of ICD-10 to Medical Practices.”

[2] Ibid.

[3] AMA Press Release, February 12, 2014. “ICD-10 Cost Estimates Increased for Most Physicians.”

[4] Journal of AHIMA, November 2014, “Cost of Converting Small Physician Offices to ICD-10 Much Lower than Previously Reported.”

Reference Pricing

We have all heard about accountable care organizations, patient-centered medical homes, and bundled payments – payment alternatives to current fee-for-service reimbursement. A lesser-known option is “reference pricing”.

Several studies have shown that the prices charged for healthcare usually have nothing to do with the quality of services performed: i.e. higher cost services do not necessarily mean higher quality services.[1] Reference pricing is designed to make the consumer more aware of the cost of services and give them the opportunity-and incentive-to choose a provider based on cost (and quality).

In traditional insurance, the patient is responsible for an initial deductible or co-payment and insurance pays the remainder of the contracted amount. With reference pricing, the insurer selects a “reference” price for specific services. Services at or under the reference price are paid in full by the insurer. The patient may use any provider, but if the cost is above the reference price, the patient is responsible for everything above the reference price. Some have referred to this approach as a “reverse deductible” since the insurer pays the first \$X and the consumer the rest.

Typically, the reference price is set high enough that many providers are available but low enough that patients have a significant cost for high-priced providers, creating a strong incentive for patients to compare costs between providers.[2]

One of the most well-known examples is an experiment in California in 2011. The California Public Employees Retirement System (CalPERS) capped what it would pay for hip or knee replacements at \$30,000. CalPERS had performed a study of the hospitals in the area and found that their prices for the same surgery varied from \$15,000 to \$100,000, with no “discernible” difference in quality. An analysis of this experiment found that CalPERS saved an estimated \$5.5 million in 2011 and 2012 from these surgeries, with more than 85 percent of the savings coming from hospitals lowering their prices. [3]

Reference Pricing and the ACA

Current ACA rules (enforced by the Employee Benefits Security Administration (EBSA) agency in the Department of Labor) say that health plans do not have to count out-of-pocket spending for reference-priced services toward the annual limit (details are in

the Dept. of Labor, IRS and Dept. of Human Services joint FAQ issued in October 2014.^[4]

The FAQ states that the agencies will permit the reference price to be treated as the in-network price, as long as the plan uses a reasonable method to provide adequate access to quality providers who are willing to accept the reference price. The agencies will determine whether a plan using reference-based pricing is using “a reasonable method to ensure adequate access to quality providers based on types of service, reasonable access, quality standards, exceptions process and disclosure.”

Insurers and employers support this approach and don’t want out-of-pocket costs to count toward the ACA out-of-pocket limit. They say the point of reference pricing is to address price variation within markets. And they worry that any change to the current ACA provision will decrease the amount of flexibility they have in designing plans. ^[5]

Consumer groups, unions and the Federal Trade Commission (FTC) disagree, saying that health plans can use reference pricing as a tool to limit networks and add more costs for consumers, especially if enrollees do not understand that going over the reference price can cost them thousands of dollars, with no maximum limit.

At this point, the EBSA has solicited comments and highlighted some of the risks they see with reference pricing, but left the existing policy in place with the qualifications noted above.

Pros and Cons

Pros

Experts say savings accrue from reference pricing through the combination of:

- Patients choosing providers at the reference price
- Patients paying the difference between the reference price and the allowed charge through cost sharing, and
- Providers reducing their prices to the reference price.

With reference pricing, consumers can select any provider. This helps insurance plans avoid moving to preferred or narrow networks (although an acknowledged risk is that a plan could incorporate reference pricing with a narrow network to negotiate even lower prices with providers).

Certainly, reference pricing can go hand-in-hand with consumer shopping for health providers when expensive procedures and tests need to be performed. Only [one-quarter of patients receive pre-treatment estimates from their providers](#), even though

63 percent said they are interested in knowing the full cost of the care they receive, according to the credit company TransUnion.[\[6\]](#)

Consumers with reference pricing plans would have pre-treatment estimates available to them.

Cons/Limitations

Reference pricing is limited in that it can only be applied to “shoppable” health care services. These services must typically be scheduled in advance, have more than one provider in a market, and have price data available for the different providers.[\[7\]](#) Services that meet these requirements include non-emergency surgical services such as hip and knee replacements, ambulatory diagnostic procedures such as colonoscopies, and certain advanced imaging tests and lab services. Safeway, a national chain of grocery stores, uses reference pricing not only for colonoscopies, lab and imaging tests but also ambulatory procedures such as arthroscopy, herniorrhaphy, cholecystectomy, and cardiac catheterization.[\[8\]](#)

Although reference pricing helps emphasize the wide variation in medical costs, it doesn't actually decrease healthcare spending, according to an October 2014 [report](#) from the National Institute for Health Care Reform. In the afore-mentioned California study it was found that the \$5.5 million in savings was only a fraction of the \$7 billion CalPERS spends on health care every year and those “shoppable” services only made up one-third of the claims.

At best, it was found that reference pricing would result in an overall savings of 5 percent, not counting what it would cost to run the system and also noting that such programs could create very complicated health plans. A hospital, for example, might meet the reference price for patients admitted to the hospital, but not for outpatient imaging services or laboratory tests.[\[9\]](#)

A study done in April by Fronstin and Roebuck, identified other limitations to reference pricing (RP). [\[10\]](#)

- High-cost providers may be reluctant to reduce prices unless they expect offsetting gains in volume, and providers may increase prices of non-RP health services to offset lower RP prices.

- RP may prompt providers below the reference point to increase prices to a “shadow-price” at or near the reference price, particularly if patients are insensitive to variations in prices at or below the reference price.
- Patients that prefer high-priced providers may choose to pay the higher costs.
- The effectiveness of RP could be limited in geographic regions where there are few providers (or just one) with significant market power.

In the end, similar to other health care payment “experiments,” the jury is still out on the effect of reference pricing. It has the ability to save money on “shoppable services” which make up a third of health care services. Or it may only impact a limited number of high cost procedures, but not reduce overall spending. Time will tell.

As things stand today, insurers and employers are likely to continue to experiment with reference pricing.

[1] White, Chapin and Eguchi, Megan, “[Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle](#)”

[2] Shih, MD, Terry, and Dimick, MD, Justin B., “[Is Reference Pricing the Next Big Thing in Payment Reform?](#),” *JAMA Surgery*, October 15, 2014.

[3] Appleby, Julie, “[Study Finds Savings for Employers Capping their Payments for Treatments](#),” Kaiser Health News, October 9, 2014.

[4] Kirkner, Richard Mark, “[ACA Rule Review Targets Out-of-Pocket Cost Calculation](#),” *Managed Care*, November 2014

[5] Overland, Dina, “[Feds Could Alter How Insurers Use Reference Pricing](#),” *Fierce Health Payer*, November 19, 2014.

[6] Shinkman, Ron, “[Price Transparency, Where is it Headed?](#),” *Fierce Health Finance*, December 8, 2014

[7] White, Chapin and Eguchi, Megan, “[Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle](#),” National Institute for Health Care Reform, October 2014.

[8] Shih MD, Terry and Dimack MD, Justin B, “Is Reference Pricing the Next Big Thing in Payment Reform?,” *JAMA Surgery*, October 15, 2014

[9] White, Chapin and Eguchi, Megan, “[Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle](#),” National Institute for Health Care Reform, October 2014.

[10] Fronstin, Ph.D., Paul and Roebuck, Ph.D., M. Christopher, “[Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits](#),” ebri.org, April 2014, No. 398.

How to Evaluate Risk in Physician Contracts?

As many have observed, the traditional world of “pay for volume” (fee-for-service) is evolving to a “pay for outcomes (quality)” environment. One aspect of this evolving world that doesn’t get enough attention is, “Who is taking the payment risk?”

In this article, we describe how physicians can prepare for, and manage, the risks inherent in these new forms of reimbursement.

One can argue that insurance companies traditionally took most of the risks; after all, that is the business they are in! They use sophisticated mathematical models to calculate the financial risk of their patient population using assumptions about costs and utilization. Traditionally, they tried to manage to these costs and increased premiums every year to cover increasing costs.

Increasingly, however, insurance companies are working to share the risks via risk-based contracts with their health care providers. A 2014 survey from [Catalyst for Payment Reform](#) as reported by *Medscape*, states that “although 60% of payments are still fee-for-service, 40% are now value-oriented. About half (53%) of the latter payments put providers at financial risk if they fail to meet objectives. On average, only 10% of payments to specialists and 24% to PCPs are value-oriented. Hospitals are the most affected by this approach so far. The most common value-oriented incentive is capitation, which accounts for 15% of health plans’ health spending and can force physicians to absorb losses when medical bills exceed payments. [1]

In the near future, it is expected that the majority of providers will be involved in some type of risk-adjusted payment method. The American Medical Association has defined these models:

- **Bundled Payments** – A single, “bundled” payment covers services delivered by two or more providers during a single episode of care or over a specific period of time.
- **Capitation** – Payment per person, rather than payment per service. There are several different types of capitation, ranging from relatively modest per member per month (*pmpm*) case management payments to primary care physicians involved in patient centered medical homes, to *pmpm* payments covering all professional services, to *pmpm* payments covering the total risk for

all services: professional, facility, pharmaceutical, clinical laboratory, durable medical equipment, etc.

- **Pay for Performance** – In “pay for performance” (PFP) approaches, a health insurer or other payer compensates physicians based on an evaluation of physician performance, typically as a potential bonus on top of the physician’s fee-for-service compensation.
- **Shared Savings** – Shared savings models can be roughly divided into two categories. In the first, if the total cost of all care received by patients assigned to a physician practice is lower than budgeted, the practice receives a percentage of the difference costs (i.e., a “share of the savings”). However, if total cost exceeds budgeted costs, the practice is not on the hook for any portion of the difference. The second category has the same potential upside but includes downside risk, usually “funded” by paying less than 100% of the FFS rate.
- **Withholds** – Withholds are a long-standing type of risk-arrangement. They represent a percentage of payments or set dollar amounts deducted from a provider’s contractual payment or reimbursement, which may or may not be returned to the provider depending on predetermined factors or events.

Whether or not you agree that “value-based” payment methods will decrease the cost of healthcare and provide quality health care, the push in this direction is happening at an increasing pace. As a result, physicians are advised to begin planning for, and perhaps experiment with, this new approach to reimbursement.

Physician quality measures are at the heart of the new payment models, both public and private. Performance on pre-set quality measures (and eventually on patient outcomes) determines;

- The financial bonus/penalty for the provider, and
- The gauge to determine if a practice is providing recommended services and high-quality health care.

To report this information and participate in these programs, physicians must ensure they are coding in a way that captures their real patient population.

Your Patient Population

Your patient population is a determining factor in participation with a risk-adjusted insurance plan. Understanding and managing your patient population is, or soon will be, critical to managing the practice’s finances while improving patient outcomes.

The MGMA (Medical Group Management Association) suggests practice professionals assess their patient demographics, most common diagnoses and payer mix for each provider's panel. Information such as the number of patients who have certain chronic illnesses, how often patients visit your practice and whether your patients are up-to-date on annual screenings and immunizations[2] can help a practice calculate the financial risk of their patient population and determine the potential cost and utilization. This knowledge is extremely helpful for negotiating contracts to lower financial risks for groups with higher-risk patients, by getting an extra capitation amount or case-management fee.[3]

Accurate Coding Determines your Patient Population

Under the Affordable Care Act's risk adjustment program for exchange plans, money is redistributed from insurers with healthier patient populations to those with less healthy populations. The information submitted on claims is one of the most influential factors to identify the health status of an insured population.

Understanding risk adjustment methodologies and how your coding and documentation affects "risk scores" has never been more important: your patients' risk-scores will determine whether you share in any savings, receive no additional funds, or return funds to the contracted carrier.

Missed diagnoses, inconsistent coding, and incomplete claims will lead to unfair and lower payments under risk adjustment. Coding accuracy is essential to provide better insight on the true risk associated with patients by better preparing the provider to project medical expenditures and to prepare for risk sharing arrangements.

For those providers who already have risk-adjustment contracts with insurers, complete and accurate coding and documentation is essential to keeping a practice in good standing with the insurer.

For practices not yet in a risk adjustment plan, a detailed understanding of their patient characteristics will make them more attractive to include in an insurer's network and can help negotiate better reimbursement when the practice has a high population of truly critically-ill patients.

Here are some coding tips from [Massachusetts](#) and [Northeast Pennsylvania Blue Cross Blue Shield](#) to assist providers in properly documenting their patient population.

- Accurately capture both primary and secondary conditions, particularly in more complex cases. A claim should include the ICD code of every diagnosis that was addressed during a patient case and those that influenced the member's care.
- Document only what is known at the time of the visit/encounter, coding only the known signs and symptoms present at the time the patient is seen.
- Code a condition only when it is confirmed by testing or additional results and update the medical record accordingly.
- Show that the condition or conditions were monitored, evaluated, assessed/addressed, or treated. Conditions must support all diagnoses coded for the service date and be able to stand alone for a particular date of service.
- Code to the highest level of specificity possible
- Standardize coding processes to minimize disruptions to the billing workflow
- Adopt technologies like electronic health records or voice translation software to improve accuracy and efficiency.

Using Data

Physician practices need patient population data not only for insurer contracts but also to know what the practice needs to serve that population, e.g. staffing, equipment, etc. Patient management and EHR systems are only valuable if the information derived from them helps your practice. Data can be used to know if your patients have had their preventive exams, identify the most cost-effective and non-cost-effective procedures, compare physicians within the practice and their outcomes, gauge patient satisfaction and much more. All of this information can be used to understand the financial aspects of your practice, how well your practice delivers quality services and where improvements can be made.

Analyzing data will help practices make the decision whether to enter any of the new payment models and will be a tremendous resource in negotiating contracts with those insurers.

Contracting

Of course, in negotiating insurance contracts, practices should present their unique value to payers. Presenting a well-run, high quality service practice will go a long way in convincing an insurer to accept your practice into their provider networks. But just as important, providers must take care of themselves and enter into contracting knowing how much risk the practice can actually handle.

Many contracts now include cost and quality metrics that lay the groundwork for narrow networks. Providers do not want to be surprised by being excluded from networks with little or no explanation, like what happened in 2014 – the most well-known by [UnitedHealthcare](#).

Practices should scrutinize contract language for “all product clauses” that give insurance companies blank checks to set payment levels and requirements to accept patients enrolled in new insurance products.^[4]

Here are some suggestions from the [American Medical Association](#) and the [Massachusetts Medical Society](#) that providers should be aware of when entering into risk-adjusted contracts with insurers:

- Providers should enter into risk-adjustment payment models that give them accountability only for costs they can successfully manage and control, not for services and costs over which the provider has little or no influence.
- It is important to know what risk adjustment methodology is used by the carrier. It should be as accurate as the best risk-adjustment system that is commercially available and the insurer should be contractually obligated to deliver any enhancement improvements that become available during the term of the contract.
- What information is used to generate risk scores
- Understanding your patient population is essential, particularly if you treat critically-ill patients. If a provider has many sick patients, either because of the nature of the specialty or because of the good quality of care given by the provider, that provider will provide more services than those providers to whom he/she is compared. This situation would lower the provider’s reimbursement, perhaps to the point where the payments will be inadequate to provide quality care to these patients. In this case, providers should negotiate for larger payments.
- The insurer should supply the provider with the publisher, product name, edition and model version of the software they will use to perform the risk adjustment along with information fully describing the software’s predictive accuracy, including R-Squared and predictive ratios.^[5] Providers should ask, “Will this software model be acceptable to predict for my types of patients?”
- Providers should review their performed services with the insurer prior to signing any contract to determine if certain services should be carved out of the contract and paid on a fee-for-service basis. These services should be specifically identified by CPT®, HCPCS, ASA and ICD-CM codes, and by any applicable modifiers.
- A practice should bring trend utilization data collected from its own systems to see whether it matches what the prospective payor considers reasonable.

- Practices need to know that the benefit plan design for the payor will not change for the practices' services, otherwise the volume of cases will increase significantly and possibly rise to an unwieldy level.

Summary

Insurers and providers will both take more risks in the next few years as part of the transition from fee-for-service to more value-based reimbursement. Physicians and physician practices will inevitably have to face these risks.

The good news is that there are proactive steps that can be taken starting today to prepare for this trend. These include:

- Understanding your patient population,
- Accurate coding,
- Collect and analyze detailed data about your practice, and
- Prepare for contracting negotiations.

In addition, these actions will better enable a practice to be successful today as well as tomorrow.

[1] Kane, MA, Leslie and Pecjham, Carol, "[Insurers Ratings Report 2014](#)", Medscape, October 21, 2014.

[2] Hyden, Madeline, "Assuming Risk For Your Patient Population, Big Data: Where do I Start," *MGMA Connection*, January 2014.

[2] American Medical Association, "[Evaluating & Negotiating Payment Options – Risk Adjustment.](#)"

[3] Hyden, Madeline, "Assuming Risk For Your Patient Populaiton, Big Data: Where do I Start," *MGMA Connection*, January 2014.

[4] Grimshaw, Heather, "The State of Medical Practice," *MGMA Connection*, January 2014.

[5] R-Squared values and predictive ratios are commonly used in the industry to evaluate the predictive accuracy of a risk adjustment model on a given population. R-Squared is an individual level measure of how much variability in the total allowed amount can be explained or predicted by the model. A perfect model has an R-Squared value of 1. A model with no explanatory power has an R-Squared value of 0. In practice, the R-Squared value is typically between 0.15 and 0.30 for prospective models on the commercial population, and no more than 0.6 for concurrent models.

Models that have R-Squared values close to these upper boundaries are more accurate and better candidates for setting provider global payments.

Predictive ratio is a group-level measure that calculates the ratio between the predicted cost and the actual cost of a certain group of people, where the group can be a disease cohort, an eligibility cohort, a cost cohort, etc. A more accurate model would have predictive ratios closer to 1.0 for the main subgroups of interest. – [“Risk Adjustment and Its Application in Global Payments to Providers,” Milliman Report, July 2011.](#)

ASCs and the 2015 OIG Work Plan

Background

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently published its [Work Plan for 2015](#), which took effect in October 2014.

There are two specific work plans for ASC services as well as general work plans that may affect ASC providers. In addition, the OIG plans to continue to focus on emerging payment, eligibility, management and IT systems security vulnerabilities in health care reform programs, such as the health insurance marketplaces. Plus, OIG plans to add to its portfolio of work on care quality and access in Medicare and Medicaid, as well as on public health and human services programs. Also, OIG will continue its examination of the appropriateness of Medicare and Medicaid payments, with possible additional work on the efficiency and effectiveness of payment policies and practices in inpatient and outpatient settings, for prescription drugs, and in managed care.

This article focuses on OIG targets that may affect physician practitioners. The information is taken directly from the 2015 Work Plan or, in some cases, shortened.

We address these OIG targets:

- ASC Targets
- General Provisions that affect Physicians and Non-Physician Practitioners
- Affordable Care Act Reviews

ASC Targets

Ambulatory surgical centers—Payment system

The OIG will review the appropriateness of Medicare's methodology for setting ambulatory surgical center (ASC) payment rates under the revised payment system. They will also determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings. A change in Federal law required the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs beginning January 1, 2008. Accordingly, CMS implemented a revised ASC payment system modeled on the Outpatient Prospective Payment System. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 626.) (See also 42 CFR § 416.171.) (OAS; W-00-13-35423; W-00-14-35423; various reviews; expected issue date: FY 2015)

Physicians—Place-of-service coding errors

The OIG will review physicians' coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service.

Prior OIG reviews determined that physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR & 414.32.)

Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, as in an ASC. (OAS; W-00-13-35113; W-00-14-35113; various reviews; expected issue date: FY 2015)

General Provisions

The following OIG work plan issues could affect physicians and non-physician practitioners and are not specialty-specific.

Enhanced enrollment screening process for Medicare providers

The OIG will determine the extent to which and the way in which CMS and its contractors have implemented enhanced screening procedures for Medicare providers. They will also collect data on and report the number of initial enrollments and enrollment revalidations approved and denied by CMS before and after the implementation of the enhanced screening procedures. As part of an effort to prevent fraud, waste, and abuse resulting from vulnerabilities in the Medicare enrollment process, CMS is implementing new authorities that include site visits, fingerprinting, and background checks, as well as an automated provider screening process. (OEI; 03-13-00050; expected issue date: FY 2015; ACA.)

Risk Assessment of CMS' Administration of the Pioneer Accountable Care Organization Model (new)

The OIG will conduct a risk assessment of internal controls over administration of the Pioneer ACO Model. (OAS; W-00-00-00000; expected issue date: FY 2015; ACA)

Medicare Advantage (MA) Organizations' Compliance With Part C Requirements

Encounter data—CMS oversight of data integrity

The OIG will review the extent to which MA encounter data reflecting the items and services provided to MA plan enrollees are complete and consistent and are verified for accuracy by CMS.

Prior CMS and Office of Inspector General (OIG) audits indicated vulnerabilities in the accuracy of risk adjustment data reporting by MA organizations. (CMS's *One Time Notification*, Pub. 100-20, CR 7562.) (OEI; 00-00-00000; expected issue date: FY 2016)

Risk adjustment data—Sufficiency of documentation supporting diagnoses

The OIG will review the medical record documentation to ensure that it supports the diagnoses MA organizations submitted to CMS for use in CMS's risk-score calculations and determine whether the diagnoses submitted complied with Federal requirements. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to CMS by MA organizations. MA organizations are required to submit risk adjustment data to CMS in accordance with CMS instructions. (42 CFR § 422.310(b).) Payments to MA organizations are adjusted on the basis of the health status of each beneficiary, so inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. (Social Security Act, §§ 1853(a)(1)(C) and (a)(3).) (OAS; W-00-14-35078; W-00-15-35078; various reviews; expected issue date: FY 2015)

Controls To Prevent Improper Medicaid Payments

Duplicate payments for beneficiaries with multiple Medicaid identification numbers

The OIG will review duplicate payments made by States on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and identify States' procedures or other controls for preventing such payments. A preliminary data match identified a significant number of individuals who were assigned more than one Medicaid identification number and for whom multiple Medicaid payments were made for the same period. (OAS; W-00-14-31374; various reviews; expected issue date: FY 2015)

National Correct Coding Initiative edits and CMS oversight

NCCI edits were introduced to Medicaid claims in 2010 and states were permitted to deactivate some or all NCCI edits because of conflicts with State laws, regulations, administrative rules, payment policies and/or States' level of operational readiness. A state's level of operational readiness is no longer a permissible basis for deactivation. The OIG will review selected States' implementation of National Correct Coding initiative (NCCI) edits for Medicaid claims and describe CMS's oversight of NCCI edits. (OAS; W-00-15-31459; various reviews; expected issue date: FY 2015; and OEI; 09-14-00440; expected issue date: FY 2015, ACA)

Affordable Care Act Reviews

The OIG will assess the Department's implementation and operation of ACA programs and progress toward achieving program goals. They will prioritize their work in three main areas:

1. The health insurance marketplaces, including financial assistance payments;
2. Medicare and Medicaid reforms; and
3. Grant expenditures for public health programs.

In addition to performing the specific work described below, the OIG is committed in FY 2015 to initiating at least 5-10 additional reviews addressing ACA programs. These reviews could focus on:

- may arise in connection with the second open enrollment period;
- Implementation of additional marketplace functionality, such as the redetermination process; or the premium stabilization programs.
- Other ACA areas, including Medicaid expansion, new Medicare payment and delivery models, or new grant programs.

Specific targets for 2015 are:

Health Insurance Marketplaces, Financial Assistance Payments, and Market Stabilization Payments

The OIG will focus on the proper expenditure of taxpayer funds, enrollment, management and administration of marketplace programs and security of information technology and consumer information such as:

- Accuracy of aggregate payments to qualified health plan issuers for advanced premium tax credits and cost sharing reductions and effectiveness of related internal controls
- Accuracy of Advance Premium Tax Credits and Cost Sharing Reductions payments for individual enrollees (new)
- CMS's internal controls over Advance Premium Tax Credit obligations and payments Under the Affordable Care Act (new)
- Programmatic justification for CMS's involvement in Premium Tax Credit obligations under the Affordable Care Act (new)
- Review of Affordable Care Act establishment grants for State marketplaces (new)

Payments to Federally Facilitated Marketplace contractors

- Consumer Operated and Oriented Plan Loan Program—Eligibility status and use of startup and solvency loans
- Review of Grant Awards to Navigators in Federally Facilitated or State Partnership Marketplaces (new)

Eligibility—Are the right people getting the right benefits?

- Review of Affordable Care Act enrollment safeguards at additional State marketplaces (new)
- Review of the Federally Facilitated Marketplace's eligibility verifications for Premium Tax Credits (new)
- Inconsistencies in the Federally Facilitated Marketplace applicant data

Management and Administration—Is the Department managing and administering marketplace programs effectively and efficiently?

- Implementation of the Federally Facilitated Marketplace
- Acquisition planning and procurement for the Federally Facilitated Marketplace
- Oversight of Federally Facilitated Marketplace contractors

Security—Is consumers' personal information safe?

- CMS's implementation of security controls over consumer information obtained in the Federally Facilitated Marketplace

ICD-9 vs ICD-10 – Disorders of the Female Genitourinary System

Diagnosis: Disorders of the Female Genitourinary System

The following are common diagnoses of the female genitourinary system that are seen in the anesthesia setting.

ICD-9 Code(s): 617.0 – 617.8, 620.0 – 620.2, 621.0 – 621.33, 622.2 – 622.12

Listed Under: [Diseases of the genitourinary system 580-629](#) > [Other disorders of female genital tract 617-629](#)

ICD-10 Code(s) N80.0 – N80.8, N83.0 – N83.29, N84.0 – N84.1, N85.00 – N85.02, N87.1 – N88.2

Listed Under: Diseases of the genitourinary system [N00-N99](#) > Noninflammatory disorders of female genital tract [N80-N98](#)

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Endometriosis	617	N80	Endometriosis, Unspecified
Endometriosis of uterus	617.0	N80.0	Endometriosis of uterus
Endometriosis of ovary	617.1	N80.1	Endometriosis of ovary
Endometriosis of fallopian tubes	617.2	N80.2	Endometriosis of fallopian tubes
Endometriosis of pelvic peritoneum	617.3	N80.3	Endometriosis of pelvic peritoneum
Endometriosis of other unspecified sites	617.8	N80.8	Other Endometriosis
Non-inflammatory Disorders of ovary, fallopian tube, and broad ligament	620	N83	Noninflammatory disorders of ovary, fallopian tube and broad ligament
Follicular cyst of ovary	620.0	N83.0	Follicular cyst of ovary
Corpus luteum cyst of hematoma	620.1	N83.1	Corpus luteum cyst
Other and unspecified ovarian cyst	620.2	N83.20	Unspecified ovarian cyst
		N83.29	Other ovarian cyst
Disorders of uterus, not elsewhere classified	621	N84	Polyp of Female Genital Tract
Poly of corpus uteri	621.0	N84.0	Poly of corpus uteri
Endometrial hyperplasia, unspecified	621.30	N85.00	Endometrial hyperplasia, unspecified
Simple endometrial hyperplasia w/out atypia	621.31	N85.01	Benign endometrial hyperplasia
Complex endometrial hyperplasia w/out atypia	621.32	N85.01	Benign endometrial hyperplasia
Endometrial hyperplasia w/atypia	621.33	N85.02	Endometrial intraepithelial neoplasia [EIN]
Noninflammatory disorders of cervix	622	N87	Dysplasia of cervix uteri
Leukoplakia of cervix	622.2	N88.0	Leukoplakia of cervix
Stricture and stenosis of cervix	622.4	N88.2	Stricture and stenosis of cervix
Mucous polyp of cervix	622.7	N84.1	Polyp of cervix
Dysplasia of cervix, unspecified	622.10	N87.9	Dysplasia of cervix, unspecified
Mild dysplasia of cervix	622.11	N87.0	Mild cervical dysplasia
Moderate dysplasia of cervix	622.12	N87.1	Moderate dysplasia of cervix