Centers for Medicare & Medicaid Services
Basic Introduction to ICD-10-CM National Provider Call
Moderator: Ann Palmer
March 23, 2010
1:00 p.m. EST

Operator: Good afternoon. My name is Chrissy, and I will be your conference operator today. At this time I would like to welcome everyone to the Basic Introduction to ICD-10-CM Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star, then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you. Ms. Ann Palmer, you may begin your conference.

Ann Palmer: Thank you. And as Chrissy said, I'm Ann, and I'll be moderating today's conference call. Please note that this call is being recorded and that the written and oral transcripts will be posted shortly. You can find call transcripts and discussion materials for this conference call by visiting www.cms.hhs.gov/icd10 and selecting CMS Sponsored Calls on the left side of this web page. Our first speaker is Pat Brooks, who is senior technical advisor at CMS. She is going to provide information about the requirement to report ICD-10-CM/PCS codes for services provided on or after October 1, 2013, and that ICD-9-CM codes will not be accepted after October 1, 2013. Go ahead, Pat, please.

Pat Brooks: Thank you, Ann, and I want to welcome everybody, and I'm glad you're all participating in this basic introduction to ICD-10-CM. And I do want to acknowledge Sue Bowman, our next speaker from AHIMA for all her efforts in developing this overview, this basic information of ICD-10-CM, which is the diagnosis part of this coding system. And for those of you who have not found it, the website does have the slides that we're following along today. And in addition, there's a very helpful document called a Quick Reference Information so that for some of you who have

heard this call and would like to perhaps brief other people that you work with in your company or organization on the basics of ICD-10-CM, that Quick Reference Information Guide should be useful to you to explain very elementary things about the new coding system.

But I'll turn now to the implementation of ICD-10, and if you'll look at slide three, you'll see that on January 16, 2009, we published a final rule that requires the implementation of ICD-10. And that final rule requires a compliance date of October 1, 2013, for the implementation of both ICD-10-CM, which is the diagnosis section, and ICD-10-PCS, the procedure section. And those of you who would like to read that final rule, I do provide the link on slide three where you can get additional information.

Moving on to slide four, I'll discuss a few important facts about ICD-10 implementation. First of all, is that there is a single implementation date for all users. I must stress quite strongly that October 1, 2013, will be the date that everyone will begin to use ICD-10. So if you were working in an ambulatory care center or a physician office and you see patients on October 1, 2013, on that date you must start coding your diagnoses in ICD-10. If you were in a hospital inpatient setting, for patients discharged on or after October 1, 2013, that will be the date that you must begin using ICD-10 codes. And to stress this it the other way, ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013. Now, we do acknowledge that some of you may be coding bills that are a little after the fact, and say for August, maybe you do not submit bills until October or November. And we do know that payers will be receiving ICD-9 codes for over a period of time. But they will be ICD-9 codes for services prior to October 1, 2013. And one last important bullet point, the bottom of slide four is there will be no grace period. In other words, we will not be slipping the date beyond October 1, 2013, for ICD-10 codes. And this will be a compulsory implementation of these systems. Thank you.

Ann Palmer: Our next speaker is Sue Bowman, who is director, coding policy and compliance, at the American Health Information Management Association. In her role as one of the ICD-9-CM Cooperating Parties, she will be presenting today. The Cooperating Parties represent a long-standing public and private sector partnership between AHIMA, CMS, the American Hospital Association, and the Centers for Disease Control and Prevention. Please note that CMS does not endorse outside organizations' materials or activities. Sue is going to provide information about the benefits of ICD-10-CM, key similarities and differences between ICD-9-CM and ICD-10-CM, general structure and characteristics of ICD-10-CM, new features in ICD-10-CM, setting the record straight about common ICD-10-CM myths and misperceptions, and impact of ICD-10-CM on medical record documentation. Go ahead, Sue, please.

Sue Bowman: Thank you, Ann. And before I get started talking about ICD-10-CM, I was asked to mention that if you have an AHIMA credential in which to claim CEUs for today's program, today's 90-minute program, it is worth 1 CEU. Simply report the CEU for this program as part of your AHIMA CEU reporting cycle and maintain documentation about today's program, such as this slide presentation, in case of an audit. For additional information about AHIMA's CEU requirements, you can find a Recertification Guide on the AHIMA website. For those of you who may be credentialed by other organizations and you're not sure of the CEU reporting requirements for that organization, please contact the respective organization for further information.

So now to get started. Why are we moving to ICD-10-CM? Well, coded data are used much more widely now than when the U.S. transitioned to ICD-9-CM 30 years ago. There are many users of the coded data contained in multiple computer databases, and the list on slide six provides you with just some of the uses for which coded data are being used for today. So in order to make best use for these purposes, we really need to move forward with a more up-to-date and modern coding system. There are also other changes within health

care that changes our opportunities when using ICD-10. For example, emerging health care technologies, new and advanced technologies, and the need for interoperability amid the increase in electronic health records requires a standard code set that's expandable and sufficiently detailed to accurately capture current and future health care information.

Moving to slide 7, first of all, what is ICD-10-CM? Well, it's a diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings and is intended to replace the ICD-9-CM diagnosis coding system. It is a U.S. clinical modification of the international classification system, ICD-10. This slide gives you some bullet points for a reference on the comparison between the structure of ICD-9 and ICD-10-CM. An ICD-9 code has three to five characters or digits in comparison to three to seven characters in ICD-10-CM. The first character of an ICD-10-CM code is always an alpha character. And all letters of the alphabet are used except for U, while in ICD-9-CM the first character is numerical except for the V and E codes. The letters I and O are used in ICD-10-CM, but they shouldn't be confused with the numbers 1 and 0 because the letters I and O are only used in the first character position. And this character is always a letter. In ICD-9-CM characters two through five are numeric. In ICD-10-CM, character two is numeric and characters three through seven can be either alpha or numeric. In both coding systems, all codes are always at least three characters long, and both systems use a decimal after the first three characters of the code. Also, another feature of ICD-10-CM that's a little bit different is a dummy placeholder of "X" that's used in certain characters of some codes. And I'll explain about the use of this placeholder a little bit later. The alpha characters in ICD-10-CM are not case sensitive, meaning that a lower-case or upper-case version of the same letter has the same meaning.

On slide 8, this gives a depiction of the current structure that we're familiar with in the ICD-9-CM codes, showing that a code like 496

might only be three characters long. 414.00 is an example of a five digit code, and then V55.3 is an example of a code using an alpha character in ICD-9. Again, codes longer than three characters always have a decimal point after the first character. The first character can be alpha or numeric, but only alpha codes are used for the V and E codes, not in the other chapters of ICD-9. And the second through fifth characters are always numeric.

In contrast, in ICD-10-CM, it does have the same hierarchical structure as ICD-9. And all codes with the same first three characters have common traits, with each character beyond the first three adding more specificity. But in ICD-10-CM there can be up to seven characters. Just like in ICD-9-CM, some codes may only be three characters long. For example, P09, which is the code for abnormal findings on neonatal screening, is a complete code. Just like in ICD-9-CM a decimal appears after the third character. Some codes in certain chapters of ICD-10-CM have a seventh character, sometimes referred to as a seventh character extension. It's used in the obstetrics, musculoskeletal injuries, and external causes of injuries chapters. A code that has an applicable seventh character, even though it's sometimes called an extension, is considered invalid without the seventh character. And the seventh character value must always appear in the seventh character position. Occasionally, a code that requires a seventh character is less than six characters long. In that case, a placeholder of "X" is used to fill in the empty characters so that the seventh character value can appear in the seventh character position. For example, code S77.11, crushing injury of right thigh, requires a seventh character to indicate whether it's the initial encounter, subsequent encounter, or sequela. Since this code is only five characters long and "X" must be placed in the sixth character position in order to appropriately put the seventh character in the seventh character position. So the complete code assignment would be S77.11X followed by the seventh character indicating initial, subsequent encounter, or sequela for the complete code assignment. The seventh character has a different meaning depending on the

section but often provides information such as the characteristic of the encounter. For example, in the injury and external cause sections, the seventh character classifies an initial encounter, subsequent encounter, or sequela or late effect. Certain codes, such as fractures, have even more specificity provided by the extension. In the OB chapter, the seventh character is used to identify the fetus affected by the OB condition described by the code when it is a multiple gestation. And – I'll talk –I'll have an example of that a little bit later.

On slide 10, more similarities between ICD-9 and ICD-10-CM are in the structure and format. When you take a look at it, it looks very similar to ICD-9-CM. The chapters are structured very similarly with some minor exceptions. A few chapters have been restructured. And the sense organs, meaning the eye and the ear, have been separated from the nervous system chapter in ICD-10-CM and moved to their own chapters. The index is structured the same as ICD-9-CM where you have an Alphabetic Index of Diseases and Injuries, Alphabetic Index of External Causes, a Table of Neoplasms, and a Table of Drugs and Chemicals.

Just like in ICD-9-CM, ICD-10-CM is divided into an Alphabetic Index and a Tabular List. The index is an alphabetical list of the terms and their corresponding codes. It lists the main terms in alphabetical order with indented subterms under the main terms, just like in ICD-9-CM. And, again, the index is divided into two parts – the Index to Diseases and Injuries and the Index to External Causes.

In ICD-10-CM, the Tabular List is a chronological list of codes divided into chapters based on body system or condition. The Tabular List is presented in code number order. Since all ICD-10-CM codes start with a letter, all code categories are in alphabetical order according to the first characters. So, for example, chapter one contains code categories A00 to B99. And chapter two contains code categories C00 to D49. And chapter three contains code categories D50 to D89 and so forth. Then within each chapter or section beginning with the same

letter, the code numbers are listed numerically. And just as in ICD-9-CM, codes are invalid if they are missing an applicable character. You look a code up the same way in both ICD-9 and ICD-10. First, look up the diagnostic term in the Alphabetic Index and then verify the code number in the Tabular List. One nice feature in the ICD-10-CM codes is that full code titles are provided for the code descriptor. As many of you know in ICD-9-CM, you frequently have to refer back to the beginning of a code category or even back to an earlier section to identify the applicable fourth or fifth digit for a code. And sometimes in ICD-9-CM, a code title only contains some of the words for the code description, and you have to look at the title of the category the code is under in order to know the complete meaning of the code. By contrast, ICD-10-CM provides the complete code titles for each code. The only exception for that is for those codes that require a seventh character, you do have to refer back to the beginning of that category to identify the appropriate seventh character value. But for all of the other codes that don't involve the seventh character and for the descriptor of the code for all pieces of information except that seventh character, the complete code title is provided next to each code number.

On slide 13, many conventions have the same meaning in ICD-10-CM that they had in ICD-9-CM. Many of the abbreviations, punctuation, symbols, familiar notes (such as code first and use additional code note) are used. Nonspecific codes, meaning the codes with words such as "unspecified" or "not otherwise specified' in the code titles, are available to use when detailed documentation to support a more specific code is not available.

The ICD-10-CM Official Guidelines for Coding and Reporting accompany and complement the ICD-10-CM conventions and instructions, just as we have ICD-9 official coding guidelines today. And the ICD-10-CM official guidelines are currently available along with the code set on the CDC and CMS websites. Adherence to the official coding guidelines in all health care settings is required under HIPAA, just as it is with ICD-9-CM.

All of the codes, as I mentioned, in ICD-10-CM are alphanumeric. So this is one of the differences from ICD-9. The first character is always alpha. The codes can be up to seven characters in length. Many of the code titles are much more specific than the ICD-9 code titles. And you'll see some examples of that a little bit later. And, again, the code titles are much more complete, where there is no need to refer back to a category or subcategory level to determine the complete meaning of a code.

Laterality, meaning the side of the body that's affected, has been added to appropriate chapters including the eye and adnexa, the ear and mastoid process, the neoplasm, and injury chapters. This feature allows you to appropriately classify the right or left side or bilateral. This information is often currently readily available in the medical record but because ICD-9-CM does not capture this information, this data are not being collected. And if the affected side of the body is not documented, there are codes for unspecified side.

One of the great new features of ICD-10-CM is the creation of combination codes for conditions and common associated symptoms or manifestations. This allows one code to be assigned rather than multiple codes and provides a clear linkage between the underlying condition and the associated symptom or manifestation. Another – poisonings and associated external causes – are another example of the use of combination codes with ICD-10-CM. One change in the structure in ICD-10-CM is that injuries are grouped by anatomical site rather than by categories of injury. So all injuries of a site, like head and neck for example, are grouped together rather than grouping together injuries according to type such as all fractures together or all open wounds together. And, of course, one of the major benefits of ICD-10-CM is that the codes reflect modern medicine and updated medical terminology. On slide 17 are some examples of combination codes, and it also shows some of the increased detail that we get out of the ICD-10-CM codes. So I25.110 is atherosclerotic heart disease of native coronary artery with unstable angina. E11.311 is type II

diabetes with unspecified diabetic retinopathy with macular edema. K71.51 is toxic liver disease with chronic active hepatitis with ascites. K50.012 is Crohn's disease the small intestine with intestinal obstruction. And N41.01 is acute prostatitis with hematuria.

On slide 18, this shows you the differences in how injuries are structured within ICD-9 versus ICD-10. So in ICD-9, you have injuries grouped together by the type of injury. So all fractures are in one section, dislocations in another section, and sprains and strains in another section. In ICD-10, they've been reorganized. So it's all the injuries to the head, all the injuries to the neck, all the injuries to the thorax, and so forth. And within those sections are the different codes for the types of injuries that can occur at that anatomical site.

And I had mentioned earlier that a seventh character is one of the additional features in ICD-10-CM. It's used in certain chapters to provide additional information, most typically about the characteristic of the encounter. As I mentioned, it must always be in the seventh character position. And if a code has an applicable seventh character, the code must be reported with the appropriate seventh character value in order to be valid.

For injuries, the seventh character typically identifies whether this is the initial encounter for the injury, a subsequent encounter, or sequelae – meaning late effect. For fractures, in addition to identifying the initial or subsequent encounter, the seventh character also provides information about routine versus delayed healing, malunion versus nonunion, and certain types of open fractures. And the OB chapter – the seventh character, again, identifies the fetus for which the code applies in cases of multiple gestations. For example, the seventh character would be used with codes for fetal anomalies or malposition of the fetus to identify which fetus the codes for these conditions apply to when there are multiple fetuses. Here's an example of the seventh character for the injuries and external causes, with A indicating the initial encounter, D indicating subsequent, and S

for sequelae. Note that one big change in ICD-10-CM is – excuse me – instead of using aftercare codes like we're used to today for follow-up care for injuries, aftercare of an injury in ICD-10-CM is captured by assigning the acute injury code with the seventh character D, indicating that it is a subsequent encounter.

On slide 21, some of examples of some of the additional types of seventh character values that are used for fractures where closed versus open fracture is captured, routine versus delayed healing, and nonunion versus malunion.

I had mentioned earlier that ICD-10-CM uses a dummy placeholder "X" in some codes. So now I'll talk about the places in which this placeholder is used. It's used in certain codes as a fifth character placeholder where it will appear – in the – in the code itself, in the classification, in order to allow for future expansion in that area. So, for example, codes involving drugs are an area where this placeholder is used because there can be such an explosion and expansion in the types and categories of drugs. It's also used to fill in empty characters when a code that is less than six characters in length requires a seventh character. And I had provided an example of that earlier where if the code is shorter than six characters and it must have a seventh character, you need to use the placeholder "X" to fill out the empty characters. When the placeholder character applies, it must be used in order for the code to be valid.

In ICD-9-CM, Excludes notes can have multiple meanings. Now I'm on slide 23. An Excludes note in ICD-9 can mean either that the code identified in the Excludes note should never be assigned with the code where the note appears, or it can mean that the code identified in the Excludes note is not included in the code where the note appears, and it would be appropriate to assign both codes when both conditions are present.

This can be confusing to a lot of coders because sometimes it may be readily apparent which kind of Excludes note it is, and sometimes it's not so apparent. For example, when an Excludes note for an acquired condition appears under the code for the congenital form of this condition, it's pretty clear that you shouldn't assign both the congenital and acquired codes since they're mutually exclusive. And the patient can only have either the congenital or acquired form of a condition, not both. That's pretty clear. But there are many other instances of Excludes notes in ICD-9 where it is not that clear whether the codes can be used together or not. And that's created a lot of difficulty and a lot of coding questions. However, ICD-10-CM clears this confusion up by providing two different types of Excludes notes – Excludes1 and Excludes2. An Excludes1 note indicates that the code identified in the note and the code where the note appears cannot be reported together because the two conditions cannot occur together. And here is an example on slide 23 of diabetes, where there is an Excludes1 note indicating that it excludes diabetes due to underlying condition, or drug or chemical induced diabetes, or gestational diabetes. So in other words, the patient wouldn't have type 1diabetes and diabetes due to an underlying condition. It has to be one or the other. So this makes it very clear that these codes cannot be reported together. You cannot assign an E10 code for type 1 diabetes with an E08 code for diabetes due to an underlying condition.

On slide 24, an additional example of the acquired and congenital situation is M21, other acquired deformities of limbs, which has an Excludes1 for acquired absence of limb and congenital absence of limb – meaning that, if that's really what you're looking for and what you mean by the code, then you need to use this other code and not the M21 code. You shouldn't be using the M21 with either one of these codes identified in the Excludes1 note.

On slide 25, an Excludes2 note, on the other hand, indicates that the condition identified in the note is not part of the condition represented by the code where the note appears. So both codes may be reported

together if the patient has those conditions. For example, L89 pressure ulcer, has an Excludes2 note for diabetic ulcers, and nonpressure chronic ulcer of skin, and skin infections, and varicose ulcers. A patient could conceivably have other types of ulcers in addition to a pressure ulcer. So if they do, it's okay to assign the other codes for the other kinds of ulcers in addition to the L89 code for the pressure ulcer.

On slide 26, an additional example of an excludes2 note is I70.2, atherosclerosis of native arteries of the extremities, where there's an Excludes2 note for atherosclerosis of bypass graft of extremities. It's possible to have atherosclerosis in both the native artery and a bypass graft. So if the patient has both, the I70.2 code and the code for the bypass graft atherosclerosis may be used together.

On slide 27, I've provided some examples of the increased specificity in some of the ICD-10-CM codes. For example, S72.044G, nondisplaced fracture at the base of the neck of the right femur, subsequent encounter for closed fracture with delayed healing. You can see how much more information is in that code that you know about the patient that you don't get from many of the current ICD-9-CM diagnosis codes. I69.351, sequelae of cerebral infarction with hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Again, you can see how much additional information is in that code description. Z47.81, encounter for orthopedic aftercare following surgical amputation. And Z48.21, encounter for aftercare following heart transplant.

On slide 28, I've provided some examples of where laterality is used to show which side a malignant neoplasm of the breast appears on. And you can see the additional information that having that laterality information provides.

Now on slide 29, we're going to walk through a few coding examples just so you can see the process of how to code an ICD-10-CM. And understand that while some of the codes are different or all the codes

are different and how they might look different, and be longer, and have some different aspects to them – the general coding process is very much the same. So here on slide 29, we're going to walk through the process of coding hypertension. First, you look up the term in the Alphabetic Index, and unfortunately in this format I can't show you what the entire code book would look like, but they're listed alphabetically by named diagnostic term just as the Alphabetic Index is organized in ICD-9-CM. So you just picture that you're looking at a page of a code book with "H's" on it, and you're scrolling down, and you find hypertension. And you'll see that it has, you know, some nonessential modifiers in parentheses after the term, just like we're used to today, and then gives the code I10. So then the next step in the process is to verify the code in the tabular. So you go to I10 in the tabular. Again, the code numbers are listed in the Tabular List in chronological order, starting with the letter that appears in the first character position. So to find I10, you would go to the code starting with the letter "I" and then find I10 in numerical order after I09.9 and before I11. And you'll confirm that I10 – is the – is the code for hypertension. And there you will see some inclusion terms and some excludes notes, just like you would be used to seeing in codes in ICD-9-CM.

On the next slide, slide 31, here's another example, again, of looking the term type diabetes up when you're trying to code Type I diabetes with diabetic nephropathy. Look up diabetes, find the indented term of Type I, and then a further indented subterm of with nephropathy, which gives you E10.21.

And on the next slide, you verify the code in the tabular by looking up E10.21, which appears under category E10. And then within subcategory E10.2, and you will see the code E10.21, Type 1 diabetes with diabetic nephropathy, listed there along with some inclusion terms underneath it.

On slide 33, we're looking up stage III decubitus ulcer of the coccyx. You would first look up ulcer, and then you would decubitus, and then it would tell you to "see ulcer, pressure, by site." So you will notice the same use of the cross-reference word "see" that we're used to seeing in the ICD-9 Alphabetic Index. You'll go then to ulcer pressure and then you could look under a subterm, an indented term of coccyx, or you could look under the indented term under ulcer, pressure, for stage III, and then coccyx, both of them referring you to L89.15.

On the next slide, you'll see you go to L89.15 in the Tabular List, and you will note that L89.15 is not a complete code. So this is a good example of why you should never code from the Alphabetic Index and should always verify the codes in the Tabular List. Because you will see that L89.15 is actually a subcategory for pressure ulcer of sacral region that is further broken down into six character codes indicating the stage. So the correct code for the diagnosis we're trying to code, stage III decubitus ulcer of coccyx, is actually L89.153, within that L89.15 subcategory.

On slide 35, if you were going to look up postmenopausal osteoporosis with current pathological fracture, the vertebra, and this is the initial encounter for the fracture, you would start by looking up the main term osteoporosis and postmenopausal. And the line on your slide there that says "with pathological fracture" was inadvertently omitted from your slide. But – so just picture that under postmenopausal, if you had another indented line there, it should say "with pathological fracture." And then underneath that would be a further indented term, of vertebra, referring you to M80.08. If you go to M80 in the tabular and look down to M80.08, you will see the code there for age-related osteoporosis with current pathological fracture of the vertebra. You will see under M80 the appropriate seventh character value for the codes in this category, and so we know it's the initial encounter. So the seventh character is an "A." However, notice that M80.08 is only five characters long. And remember what I talked about earlier, that a seventh character value must always be in the seventh character

position. So you would report M80.08x – the placeholder “x” – and then the “A” in the seventh character position.

On slide 37, for dislocation of the jaw, subsequent encounter. Again, you would look up the main term, dislocation of jaw, which then sends you to S03.0 in the tabular. You would verify the code in the Tabular List and see the code for dislocation of jaw. And, again, this particular code requires a seventh character. And in this case, S03.0 is only four digits long. So it requires a placeholder “x” in both the fifth and the sixth character positions in order to put the “D,” for the subsequent encounter, in the seventh character position.

On slide 39, late effect of stroke with facial droop. Again, look up late effect. You’ll see an instructional note to see sequelae. And you look up sequelae, there will be an indented term of stroke. And then a further indented term under that of facial droop, sending you to I69.392.

And when you verify that in the Tabular List on slide 40, you will see that I69.392 is the correct code, facial weakness following cerebral infarction, and it includes facial droop according to the inclusion terms.

On slide 41, you’re coding aftercare following hip replacement. The hip replacement is not for a fracture because there are different rules for fractures. You would look up aftercare following surgery of the indented term, and then under that joint replacement as a further indented term, which indicates Z47.1.

And then when you verify the code in the Tabular List, you will see Z47.1, aftercare following joint replacement surgery with a use additional code note underneath indicating that you would add a code to indicate what joint is affected. And, again, notice the familiar use of many of the notes we’re familiar with in ICD-9 such as this use additional code notes. So that kind of gives you some examples of how you go about the process of looking up codes in the ICD-10 and

verifying the final code assignment. And how many of the steps in the process are very much the same as ICD-9 that you should be familiar with.

On slide 43, I'm just going to talk a couple of minutes about some of the ongoing myths about ICD-10. And these were taken from the ICD-10 fact sheet on myths and facts that's posted on the CMS website. One myth is that there won't be any hardcopy ICD-10-CM code books, and that all coding will need to be performed electronically. Well, that's not true. ICD-10-CM code books are actually already available by some publishers. And I can vouch for the fact that they are a normal, manageable size and not 10 feet thick or anything like that. The use of the ICD-10-CM is not predicated on the use of electronic hardware and software. Of course, just as with ICD-9-CM, there will be encoders and other electronic tools available to facilitate the coding process. But it's not required that people use electronic tools in order to use the ICD-10-CM.

On slide 44, another myth is that unnecessarily detailed medical record documentation will be required. Well, as with ICD-9-CM, ICD-10-CM codes should be based on medical record documentation. And while documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when the documentation doesn't support a higher level of specificity. In fact, in a field testing study of ICD-10-CM conducted by the American Hospital Association and AHIMA, much of the details contained in ICD-10-CM is already in the medical record documentation, but it's just not being utilized because it's not needed for the ICD-9-CM codes.

Another myth is that the increased number of codes will make ICD-10-CM impossible to use. Well, just as the size of a dictionary doesn't make a dictionary more difficult to use, a higher number of codes doesn't necessarily increase the complexity of the coding system. In fact, greater specificity makes it easier to find the right code because it's clearer that you're in the right place. Because ICD-10-CM is much

more specific and more clinically accurate and uses a more logical structure, it can be much easier to use than ICD-9-CM. And just as it isn't necessary to search the entire list of ICD-9-CM codes for the proper code, it's also not necessary to conduct searches of the entire list of ICD-10 codes to find the right code. As I showed you with the examples earlier, you follow the same process of looking up the terms in the index and then going to the tabular to identify the appropriate code for the condition you're trying to code. The index and electronic coding tools will continue to facilitate proper coding selections just as they do with ICD-9-CM. And it is anticipated that the improved structure and specificity of ICD-10-CM will facilitate the development of increasingly sophisticated electronic coding tools that will ultimately assist in much faster code selections.

On slide 47, well, what is the impact of ICD-10-CM on coding and documentation? Well, certainly the full benefits of ICD-10-CM will not be realized if we don't take advantage of the increased specificity. More detailed documentation will result in a more accurate clinical picture and better data for supporting the many purposes for which coded data are used today as well as the uses for which coded data will be used in the future. However, improved data are likely to occur even without improvements in documentation simply because the greater detail in ICD-10-CM takes advantage of the clinical information already contained in medical record documentation but that is not currently being captured by the less-specific ICD-9-CM codes. It is anticipated that improvements in ICD-10-CM such as more complete and specific code titles, updated medical terminology, and expanded and clearer instructional notes will facilitate the coding process and make it easier to code accurately and efficiently. Earlier, on one of the myth slides, I referred to a field testing study conducted by AHIMA and the American Hospital Association several years ago. This study concluded the ICD-10-CM codes can be applied to today's medical records in a variety of health care settings without having to change documentation practices although, of course, improved documentation would result in higher coding specificity in some cases. In that study,

only 12 percent of the assigned codes in the study were in the nonspecific category, meaning that they had “unspecified” or “not otherwise specified” in the code title even though physicians were not asked for clarification or additional documentation as part of the study, indicating that the medical record documentation necessary to support coding specificity was actually present in the majority of cases. In that study, 6,177 medical records in a variety of health care settings including inpatient hospital, outpatient hospital, post-acute settings, physician practices, and freestanding outpatient facilities were coded using ICD-10-CM. However, it’s important to keep in mind that nonspecific codes are still available in ICD-10-CM when the detailed documentation to support a more specific code is unavailable.

Improved medical record documentation is not predicated on the change from ICD-9-CM to ICD-10-CM. However, improved documentation is being driven by a lot of other external initiatives such as quality measurement reporting, value-based purchasing, and patient safety. So provider organizations should anticipate and try to improve documentation capture prior to ICD-10-CM implementation to avoid having to rely too heavily on unspecified codes or hold up claims trying to address documentation deficiencies retrospectively. One way to start working on assessing and improving documentation now is to review the medical record documentation for the most frequently coded conditions in your organization and compare it to the ICD-10-CM codes for these conditions.

So how to get started with training for coding personnel. Well, it’s too early to start intensive in-depth ICD-10-CM training for coding professionals. The most effective time for in-depth training of coding professionals to ensure proficiency in assigning ICD-10-CM codes is thought to be six to nine months before the implementation date. Providing the right training at the right time is necessary to ensure that there’s sufficient time for learning and to avoid retraining. Training on any particular issue should be deployed close to the effective date for the individual. And acquiring knowledge months or years before it’s

applied is not efficient, as this inevitably results in varying amounts of follow-up and retraining that consumes additional training resources. Since ICD-10-CM has the same hierarchical structure, the same basic organization, and many of the same conventions as ICD-9-CM, experienced coding professionals will not require the level of extensive training that would be necessary for an entirely new coding system. They will already be familiar with the logical hierarchy and the basic ICD rules. As I showed you earlier, many of the features of ICD-10-CM are very similar to ICD-9-CM. So experienced coding professionals will primarily need to be educated on changes in the structure, disease classification, definitions, and guidelines. So it is anticipated that those coders who are already proficient in ICD-9-CM require only a couple of days of training to make the transition. And I think that's an important point for people to realize – that it's about really two days of training for someone who is already proficient in ICD-9-CM to thoroughly learn ICD-10-CM. And that includes:

- About six hours learning the fundamentals of ICD-10-CM to understand the code structure conventions, related coding guidelines, and how ICD-10-CM is different from ICD-9-CM;
- Six hours and more intensive training applying ICD-10-CM coding conventions and guidelines; and
- Four hours practicing applying the ICD-10-CM codes to typical encounters in their organization to gain proficiency in code assignments.

So on slide 50, what can coders start doing now to prepare since it's too early for the actual intensive, in-depth coding training? Well, certainly, it's time to do exactly what you're all doing today and that's start learning about the structure, organization, and unique features of ICD-10-CM. And start using assessment tools to identify areas of strength and weakness in the biomedical sciences including anatomy, physiology, pathophysiology, pharmacology, and medical terminology. And the results of these assessments can be used to determine who might benefit in a review or a refresher course in biomedical sciences and what aspects of the biomedical sciences this review should be

focused on. Assessing individual competence allows the organization to focus on prioritized training resources, and provide training where it is most needed, and tailor the training plan to the individual. Measuring the coder's baseline knowledge now and providing refresher education where needed will help to focus limited educational resources and ensure adequate staff preparation and will ultimately shorten the learning curve, improve coding accuracy and productivity, and accelerate the realization of the benefits of ICD-10-CM.

So that concludes my presentation on ICD-10-CM. On slide 51, I've provided the website for AHIMA's ICD-10 resources. There are a variety of articles and other resources that are freely available including a practice guidance on the GEMs, the General Equivalence Maps, between ICD-9-CM and ICD-10-CM; a preparation checklist that's freely available; and there are also some role-based implementation models on our website as well. A Pocket Guide of ICD-10-CM and ICD-10-PCS is a very handy, quick reference guide available at a very nominal fee that provides a lot of quick, easy information about ICD-10 – at your fingerprints – at your fingertips without having to search through large documents. It gives you the information about the digits, the features, some of the unique characteristics, and the various chapters, implementation strategies, and so forth. There are also some online courses we offer. We have a freely-available electronic ICD-10 newsletter, some assessments that we provide on assessing your proficiency related to ICD-10 – some of those assessments I had talked about earlier in implementation planning. And we are providing academies for people who are going to train other people in ICD-10. And we do have two upcoming academies aimed at people who wish to train in ICD-10-CM only and not ICD-10-PCS, and those dates are listed here on this resource slide. And more information can be found on our website. And now I'll turn the presentation over to Pat to talk about some additional resources.

Pat Brooks: Thank you, Sue. That was very informative. Looking at slide 52, you will see that we do have ICD-10 information on our CMS website. For those of you who want even more about ICD-10 and perhaps are interested in doing a conversion project from ICD-9 to ICD-10, we do have a report on an MS-DRG conversion project that CMS undertook where we took our payment system for inpatient hospitals that's ICD-9 based and converted it to ICD-10. And in that report – I believe it's 119 pages long – we share lessons learned and make recommendations to others who are interested in undertaking a similar type of a task. The second bullet on slide 52 shows that we do have general ICD-10 information, and you should check that website periodically to look for updates.

Slide 53 shows that sometimes people, when we have these outreach calls, ask for information about what products that vendors have available. Well, two organizations have volunteered to provide information for providers on ICD-10 resources. We don't necessarily from CMS endorse any product over another, but we're pleased that groups such as WEDI and HIMSS – and you see the two websites – are making websites available for vendors to report products that they have. And that may be a good tool for you to look through. And I'll turn it back over to Ann now.

Ann Palmer: Okay. Thank you, Pat and Sue. At this time, we will answer participants' questions regarding the topics presented during today's call. Please note that specific coding questions are outside the scope of this call. Chrissy, can we go ahead and start the Q&A session, please?

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star, followed by the number one on your telephone keypad. And your first question comes from Rick Biofner. Your line is now open.

Ann Palmer: Go ahead, please.

Male: Go ahead, whoever. Somebody from MGF requested it. Maybe not.

Operator: Okay, your next …

Male: … we're bridging in. So that …

Ann Palmer: I'm sorry. We're having trouble hearing you.

Male: Okay, we've bridged in from our phone system so that may be what caused that request.

Ann Palmer: Did you – oh, you don't have a question?

Male: No.

Ann Palmer: Okay.

Male: Evidently not.

Ann Palmer: Okay, thanks.

Operator: Your next question comes from Cathleen Perlini. Your line is now open.

Cathleen Perlini: My – it wasn't actually a question. I was just hoping that the speaker could talk louder. That was the only thing I was really going to ask for. But it's finished.

Ann Palmer: Okay. Thank you.

Pat Brooks: We apologize for that.

Operator: Your next question comes from the line of Liz Blaire. Your line is now open.

Liz Blaire: Yes. I am just curious on if we get ready prior to the October 1 deadline, can we start testing and using the ICD-10 codes prior to that date?

Pat Brooks: This is Pat Brooks, and I'll respond to your question. You certainly could do some internal testing of ICD-10 and also of your 5010 system. What you can't do is that you can't submit ICD-10 codes to any other payers prior to – for services prior to – October 1, 2013. But I do commend you for thinking about maybe doing some early codings and spotting out issues. That's a very good idea. And working with your software vendors early to see if there are going to be any issues for you internally.

Liz Blaire: Okay, thank you very much.

Operator: Your next question comes from Amy Coleda. Your line is now open.

Amy Coleda: Hi. I actually have two questions. My first question pertains to the 1500 format. Will that need to be revised in order to accommodate for the additional digits that are going to be implemented with ICD-10? That's my first question.

Pat Brooks: Yes. And let me answer that question. This is Pat Brooks.

Amy Coleda: Hi, Pat.

Pat Brooks: You will need to go to a new format because you are correct that the codes are longer and so you need a new format. Beginning on or after January 1, 2011, CMS – and I'm sure other payers – will be accepting claims that are in the new format, the 5010 format, which has a lot of improvements, one of which is that it's a longer series – it accepts more characters for your codes. So, yes, that is another thing that you will need to be working on is to update – go into the new update system 5010. And I believe CMS has information on its website that can go into greater detail on 5010 than I can at this point.

Amy Coleda: And that will be also a universal claim form?

Pat Brooks: Yes, that will be – that will be the new universal claim format, yes.

Amy Coleda: Okay, and I'm sorry, can I just have that date again that that's going to be implemented?

Pat Brooks: Yes, beginning on or after January 1, 2011, CMS is going to be prepared to start accepting bills in that format.

Amy Coleda: Okay.

Pat Brooks: Now, people may phase in at different time periods, but that's the time period that we will be ready to accept that new format.

Amy Coleda: Okay. All right. Thank you for answering that. My other question is this – I want to try to ask this without sounding too confusing. Now with ICD-9, there are such things as truncated diagnoses. However, I'm not seeing – is that something that's going to be applicable as well because I see where your codes, your ICD-10 codes, can be more specific. They could be very specific, but – is there going to be – or are there going to be codes other than the requirement of that seventh digit where it could be truncated? Does that make sense, the question?

Pat Brooks: I believe I understand your question. And I believe that when Sue Bowman referred to the fact that if a code is seven digits long because it has a seventh digit qualifier that you have to report, say for injuries, then – you must – you must report all seven digits. And we'll sometimes have to put "X's" in. So the short answer to your question is – if a digit – if a code is three, four, five, six, seven digits long, you must report every one of those codes. You cannot truncate and by that I mean you cannot omit a digit. You have to report all digits required. On another issue that some people refer to when they're talking about truncated, some people use that term to describe for less specificity.

Amy Coleda: Right.

Pat Brooks: For instance, you have a fracture and you don't know right or left leg or whatever because the documentations for or whatever. Sue talked about there are codes that capture imprecise medical information. We don't encourage imprecise documentation, but ICD-9 and ICD-10 will offer you the ability to code in less precise manner. But we encourage good documentation. And we encourage the full use of ICD-9 and 10. And, yes, if the code's six, seven digits long, you must report all six, seven digits.

Amy Coleda: Okay, gotcha. All right. Thank you. That covered both ends of it.

Operator: Your next question comes from John Tice. Your line is now open.

John Tice: I have two questions as well. On the October 1, 2013, date – is that based on date of service or submission date?

Pat Brooks: That is based on date of service. So if you were in a physician's office, the patients that walk into that office on October 1, 2013, and after – you must use ICD-10. If a patient walks into the physician office on September 30, 2013, you would use ICD-9.

John Tice: Okay, thank you. And then do you know if there will be a crosswalk between ICD-10 back to ICD-9 if we start coding earlier?

Pat Brooks: Yes, and, you know, we did have an earlier outreach call. And, I'm sorry you missed that, on this exact issue. We have something that we call General Equivalence Mappings, and they're maps between ICD-9 and ICD-10. They go both ways. They go from – you can look up a 9 code and find the equivalent ICD-10 code. They go backwards. You can look up an ICD-9 code, and you can see the – it can go both ways – from 9 to 10 and 10 to 9. The paper that I referenced at the end of my slides on the MS-DRG conversion project talks about these GEMs, these General Equivalence Mappings, and how to use them. You can look at those now. They're posted on our website. And if you want to begin doing some conversion internally at your facilities, we would encourage you to use that. You will find on our website in addition to

the forward and backward mappings, we have user guides, we have user fact sheets, and we have that lengthy paper that talks about how we went through and did a conversion project ourselves. So hopefully you'll find that useful.

John Tice: Thank you very much.

Operator: Your next question comes from Tanya Bertoin. Your line is now open.

Tanya Bertoin: Can you hear me?

Pat Brooks: Yes.

Tanya Bertoin: Okay, good. I was testing on my speakerphone. I work for an ambulance facility, and our coders are not allowed to diagnose. And I noticed the ICD-10 codes are very specific. How is that going to work with the ambulance coders?

Pat Brooks: Now, if you report ICD-9 codes now, which I believe you do not.

Tanya Bertoin: Yes, we do.

Pat Brooks: Okay, if you report ICD-9 codes now, then beginning on or after October 1, 2013, you will instead of reporting ICD-9 codes – you will report ICD-10 codes. That's all types of providers. Anyone who currently does ICD-9 coding will do ICD-10 coding on October 1, 2013.

Tanya Bertoin: Yes, I'm aware of that. However, the – since we are ambulance coders, we are not allowed to diagnose the patient. So when we are coding our facilities – like, for instance, I noticed on slide 29 you had hypertension or – was it – what was it?

Female: Hypertension.

Tanya Bertoin: Okay, it was hypertensive. Instead of saying hypertensive, when we code our billing software, we have to say high or low blood pressure.

Female: Abnormal vitals.

Tanya Bertoin: Yes, or abnormal vitals.

Sue Bowman: This is Sue Bowman and – I can – I can answer that. Actually, you know, obviously this presentation wasn't long enough to go into all the different chapters and – some of the – some of the advantages, but you might be happy to know that the symptom codes are extensively expanded in ICD-10. So – if you don't – if you don't know the diagnosis yet and you can only code to the level of what you know at that point in time, there are many, many symptom codes that are available – for that kind of – for that kind of coding. So there will still be codes to describe what you do know about the patient.

Tanya Bertoin: Okay. Thank you.

Operator: Your next question comes from Mary Walton. Your line is now open.

Mary Walton: Yes. Hi. I'm just wondering what has brought on the ICD-10-CM? Why are we going into the system? I understand so we can go worldwide with the codes? Am I …

Pat Brooks: Yes, this is Pat Brooks, and that is a long story. And if you did want to have all the information about what went into this final rule, then I would urge you to read the final rule from that link on page 3 of our slides where we talk about the history of how the rest of the world did move to ICD-10. We talk about how the United States has gone through a number of iterations to get from 7 to 8 to 9 and now to 10. And in that rule, we talk about the reasons why we need to update our coding system, which is 30 years old, and the benefits to us of doing so. So we laid that out in pretty great detail. In addition, you can look at Sue Bowman's slide 6, which talks about the benefits of this improved classification system, and she gives you some examples where the greater detail will be of help.

Mary Walton: Yeah, I see that. Okay. All right, that's it. Thanks.

Operator: Your next question comes from Kim West. Your line is now open.

Kim West: Hi. I have a couple of things. I just want to verify you said these are not case sensitive, where they're capitalization or lowercase?

Sue Bowman: That's correct.

Kim West: Okay. And then also I have heard – I know that you said if, you know, basically drop dead single implementation date. However, I hear that Workers' Comp may not be following this. Is – have you heard of that?

Pat Brooks: This is Pat Brooks, and I can't comment on Workman's Comp except to say that I know that our standards office is working with them on that issue.

Kim West: Okay.

Pat Brooks: So I don't have anything else to say. But we'll tell you also that we will not be maintaining ICD-9 codes. We will not be updating it after October 1, 2013. So we don't plan to continue maintaining that system anymore.

Kim West: Okay, and also I know that you talked about the medical records, you know, now maintains most of the information that we need to go to I-10. However, my concern would be – our – for us that work in diagnostic studies and we receive orders or requisitions that, you know, we're going to struggle with obtaining more information. So – how are you going – how are we going to suggest the referring physician to give us more information?

Pat Brooks: Sue, do you want to discuss that, which is a problem today?

Sue Bowman: Yeah, that's a problem even with ICD-9 that's …

Kim West: Right.

Sue Bowman: … you know, not going to be cured with ICD-10, obviously ...

Kim West: Exactly.

Sue Bowman: … other than there are still symptom codes. In fact, there's a lot more symptom codes as I was telling the person from the ambulance company. And there are still unspecified codes when you simply can't get any more information from the physician or in some cases it's so early in the diagnostic process the physician doesn't know any more information. So, you know, as Pat had mentioned, we're still encouraging people to document as completely and accurately to the best of their knowledge as possible, but we know that that's still a problem even today and will certainly still be a problem with ICD-10. So there are codes if you just can't get any more information.

Kim West: Okay. Great. Thank you.

Operator: Your next question comes from Patrice Coop. Your line is now open.

Patrice Coop: Hi. Thanks. My question is about that cutoff date of October 1, 2013. If a provider – prior – is trying to get a prior authorization from an insurance company, we tend to do that in advance of the service. So I could see us trying to submit a prior authorization to cover a transaction in September for a service delivered in October that will then be billed sometime – in – after October 1. Will a health plan be allowed to require the ICD-10 earlier for that purpose?

Pat Brooks: You know based on these small points and the points about stays that cover the implementation period that span October 1, 2013, we are working on it internally, and I believe others are going to work on giving you specific instructions for how to handle these things that are within days of implementation. I don't know that we at CMS and others have a firm answer for you, but it's one of the issues that we definitely are going to work on program instructions on. So thank you for raising it.

Patrice Coop: Okay. So not just the prior auth piece, but you said also for like an inpatient that might span September to October?

Pat Brooks: Inpatient's probably not a good example, but if you have a bill for services, for DME or whatever, that spans a date then we are working on instructions on how we'll handle those. But those things – where inpatient – where they're discharged after October 1, 2013, that's really clear. We've got real clear guidance, it's the date of discharge, not the date they're admitted.

Patrice Coop: Oh, I remember that one now. Okay, so we'll see something about referral prior auth or DME.

Pat Brooks: I believe you will on all of that. We do have task teams working on those issues.

Patrice Coop: Thank you.

Operator: Your next question comes from Mark Sulcoff. Your line is now open.

Mark Sulcoff: Hi. Good afternoon. My question was already answered. It was about the head for formatting. Thank you.

Pat Brooks: Thank you.

Operator: Your next – your next question comes from Monte Stickler. Your line is now open.

Monte Stickler: Actually, one of the – both of the questions that I had have been answered. One was for the UB-04 for Skilled Nursing Facilities, about the ICD-10s, and the other one was, that you just answered from that lady that just called about continuing SNF stays from September to October.

Pat Brooks: Great. And hopefully we will be getting instructions out to help you with that closer to the time.

Monte Stickler: Thank you very much.

Pat Brooks: You're welcome.

Operator: Your next question comes from Michael Shay. Your line is now open.

Michael Shay: Yes. You had mentioned that the start date on this was the October 1, but then I heard the date 2011. Is it possible to submit the claims or I mean the ICD-10s to Medicare in 2011?

Pat Brooks: No. Let me try to do a little bit better job of that. The ICD-10 codes are for services on or after October 1, 2013 – that will be for ICD-10. However, as one of the earlier requestors mentioned, those are longer codes. They will not fit on the current format that you're using. So prior to the implementation of ICD-10, we have to go from what our current format is of 4010 to a improved format 5010 that has a lot of changes. One of those changes is that it allows more space for longer codes. And because we don't want to do all of this on the same day, beginning January 1, 2011, we're going to allow providers to start submitting bills using the new format. Obviously it'll have ICD-9 codes on it, but at least providers will get used to using the new formats and find out if there are any issues. They'll continue …

Michael Shay: Okay, but no or, I mean, no of the – or excuse me – none of the ICD-10 codes can be submitted to anyone prior to October 1, 2013?

Pat Brooks: Yes. You stated that beautiful. You cannot report them early, and you can't report ICD-9 codes late. It's a firm cutoff date. So, yes, you stated that wonderfully.

Michael Shay: Okay. All right. Thank you.

Operator: Your next question comes from Ulanda Perry. Your line is now open.

Ulanda Perry: Yes. Actually, my question has been answered. It was in reference to the NOS codes and the not otherwise specified codes. So thank you.

Operator: Your next question comes from Grace Shruggs. Your line is now open.

Grace Shruggs: Hi. I was wondering like after October 1, 2013, if you have claims that are out there that still haven't been paid or you're having issues, you need to do the corrected claims? Or will they accept that you want the ICD-9 on the ones prior to that? Or do you need the ICD-10 on the old claims? You know what I'm saying?

Pat Brooks: Yes, I do see what you're saying. For – claims that – for services that occur before October 1, 2013, you will always use ICD-9 codes. You will use that even if you send those bills in a couple of months late. So it's not on the date you submit the claims, it's on the date the service was provided that determines which coding system you would use. So those that you were still working on that happened in say September 2013, those will be ICD-9 codes.

Grace Shruggs: Thank you. Because I wasn't for sure if they'd already went through the system once if, you know, going back through again.

Pat Brooks: And our systems will be looking for date of service when we see those later claims come through. That's how we will determine which coding system should be used.

Grace Shruggs: Okay, thank you.

Operator: Your next question comes from Norma Wilson. Your line is now open.

Male: Can you hear me now? Hello?

Ann Palmer: We can hear you. Go ahead, please.

Male: Is there any relationship between these ICD-10 codes and the codes that are being used for pay for performance?

Pat Brooks: Let me just say this. Currently, for many events such as pay for performance, quality measures, edits, coverage decisions – all of those

are based on ICD-9 codes. For services after October 1, 2013, all of those reporting factors will be based on ICD-10 codes. So those will all have to be converted – all the measures, everything.

Male: Okay. Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from Moline King. Your line is now open.

Moline King: Our questions have been answered. Thank you.

Operator: Your next question comes from Lorraine Beegan. Your line is now open.

Lorraine Beegan: Hi, I actually have a comment and a question for Sue Bowman. I attended the AHIMA academy to train-the-trainer for ICD-10. And anyone who is out there, I just wanted to comment, that does instruction or teaches – it's a phenomenal course. So I just wanted to put that out there. But, with that said, because I teach – Sue, is there any word from AHIMA where they are going to require some type of competency by credentialed coders to state that they have the competency to code ICD-10? The AAPC has already put out the feelers for that, that they're going to have a competency exam for all coders that hold their credentials. And I was wondering if AHIMA was looking into that as well?

Sue Bowman: There will be more information coming out about that. But what AHIMA's going to require is not an exam or anything like that. It's going to be a requirement that a certain number, which will be based on which ones of AHIMA's credentials you hold, but a certain number of your CEUs for the period leading up to ICD-10 implementation will have to be in ICD-10 education.

Lorraine Beegan: Very good. I appreciate that. Thank you.

Sue Bowman: You're welcome.

Operator: Your next question comes from Kerry Peterson. Your line is now open.

Kerry Peterson: Yeah, hi. I just have two questions. If we ordered the books now for the ICD-10, do you think anything will change or be updated? Or is it already set and nothing's going to be – oh, wait – we forgot to add this in.

Pat Brooks: You know this is Pat Brooks, and I'm glad you raised that issue. We are still doing annual updates to ICD-9 and to ICD-10 once a year. At our meeting, the ICD-9 Coordination and Maintenance Committee Meeting, last week we discussed the possibility of freezing those codes updates by dramatically reducing the number of updates because a lot of people feel that it would help them do training, doing conversions, a number of things. The proposal we discussed at that meeting, that public meeting, that was received well by the audience – and we're getting comments on – is we discussed having the last major update to ICD-9 and to ICD-10 be October 1, 2011. We'll get more comments on that and hope to announce a final decision on that in September of this year. And after that date, then only codes for new diseases such as the new swine flu or new technologies would be added. So for instance, we will have continued larger updates now – maybe for another year – and then after October 1, 2011, then small numbers of updates. So the code books will change, but the number of changes would decrease under this freeze method.

Kerry Peterson: Okay, thank you. And then the other one – I was kind of going through the new ICD-10, and is there codes for screening? I know that there's a lot of codes for, you know, your laterality and all of that, but is there codes for screening, blood tests, drugs, urine?

Sue Bowman: There are some screening codes. Of course, there's screening codes in ICD-9 as well. There are, I believe, more codes for types of screening in ICD-10.

Kerry Peterson: Okay, thank you.

Operator: Your next question comes from Rene Duncan. Your line is now open.

Rene Duncan: This question is for Sue. All the information that I've been reading from AHIMA says that there should be 50 hours of training for inpatient coders and 16 hours for outpatient coders. And then today, you've mentioned that basically 16 hours would be adequate for most coders.

Sue Bowman: Well, the 16 – the focus of today's session was on ICD-10-CM only. And so the 16 hours or which is essentially two days – if you look at it if it's two eight-hour days – is for people who only need to learn ICD-10-CM. When we talk about hospital inpatient coders, they need to learn ICD-10-PCS as well, so that's where the 50 hours comes in. It's for the additional process for learning 10-PCS, which actually takes more time than 10-CM because it's so different from the 9-CM system.

Rene Duncan: Okay, thank you.

Ann Palmer: Chrissy? Operator?

Operator: Yes.

Ann Palmer: Hi. This is Ann. I think we'll take one more call – one more caller. Thank you.

Operator: Perfect. Your last question will come from the line of Dana Starkey. Your line is now open.

Dana Starkey: Yes, I have a question about Skilled Nursing Facility admissions. We bring people in with primary diagnoses of V codes, especially aftercare. And you had mentioned that that's going to change – that we now may be using the acute care for the injury with a seventh character, which would give us the aftercare. Is that correct?

Sue Bowman: Yes, there are still aftercare codes for other types of conditions, but for injuries, the instruction is that those are considered subsequent encounters for that injury.

Dana Starkey: Okay, so for a nursing facility, then, that's taking someone – that would be considered a subsequent encounter?

Sue Bowman: Correct.

Dana Starkey: All right. But what you're saying is that you still will have a V code, perhaps, for aftercare after a certain type of surgery?

Sue Bowman: Correct.

Dana Starkey: So that formula doesn't apply to every type of aftercare?

Sue Bowman: Correct. There are still aftercare codes for other conditions and post-surgical conditions and so on that you might see in home health or a nursing facility. But for injuries, because they're – you know – remember the seventh character for subsequent encounter doesn't apply to all codes in ICD-10, but it does apply to the injury codes. So for those codes, you would be capturing it as a subsequent encounter for the injury as opposed to the aftercare codes that you're used to using today.

Dana Starkey: Okay, thank you.

Ann Palmer: Okay, then. Thank you very much for your participation.

Operator: This concludes today's conference call. You may now disconnect at this time.

END