TRANSCRIPT SUMMARY

Centers for Medicare & Medicaid Services
Introduction to ICD-10-CM/PCS for Physician
Specialty Group Representatives Conference Call
Moderator: Ann Palmer
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12:30 p.m. EDT

Operator: Welcome to the Introduction to ICD-10-CM/PCS for Physicians Specialty Group Representatives Conference Call. All lines will remain in listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed for Encore replay purposes. If anyone has any objections, you may disconnect at this time. I will now turn the conference call over to Ms. Palmer. Sir - ma'am, you may begin.

Ann Palmer: Thank you. As Dara said, my name is Ann Palmer. And I will be moderating today's conference call, which we developed in order to provide you with information and resources that you may make use of when conducting ICD-10 implementation training for your members. The PowerPoint presentation that we will be discussing has been revised to correct some of the CMS web resources URLs. The revised presentation was included in the reminder e-mail message that was sent on June 12 from Valerie Haugen of CMS. Shortly after this call, we will post the PDF version of the presentation and a transcript of the call in the Downloads Section of the ICD-10 2009 CMS Sponsored Calls Web Page, which can be accessed by visiting www.cms.hhs.gov/ICD10 and selecting 2009 CMS Sponsored Calls from the left side of the page. Speakers from the four ICD-9-CM Cooperating Parties, which represent a long-standing public and private sector partnership between the Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, American Hospital Association, and American Health Information

Management Association, will be presenting today. We also have a practicing physician and a speaker from the American Academy of Professional Coders. Our first speaker today is Pat Brooks, who is Senior Technical Advisor at CMS, and she is going to provide an overview of ICD-10 implementation.

Pat Brooks: Thank you, Ann. I'll be starting from Slide 11 where we discuss the ICD-10 Final Rule. This final rule was published on January 16, 2009. An important issue in that final rule was that we did establish the compliance date for implementation for ICD-10-CM and PCS. And that compliance date is October 1, 2013. It's important to stress that there will be no delays in implementation, although some of the industries are saying that there are planned staggered times or - that that may - that we're planning to do delays. Let me make perfectly clear that there will be no delays. That is a firm implementation date. Also, as seen on Slide 11, the implementation of ICD-10 will have no impact on CPT or HCPCS codes - providers who use those now will continue to use them. And I've given you, at the bottom of Slide 11, the website where you can review the entire ICD-10 Final Rule.

Slide 12 discusses some other issues in the final rule. And one of them is the issue I just discussed of a single implementation date for all users. This is how that'll work - on October 1, 2013, for all ambulatory and physician services that occur on that date or later, you will begin using ICD-10. You will actually be using ICD-10-CM, the diagnosis part. Now in hospitals, they will begin using the ICD-10 for discharges that occur on October 1, 2013. ICD-9-CM codes will not be accepted for services that are provided on or after October 1, 2013. And we do recognize that as providers are coding claims prior to that implementation date, we will have ICD-9 claims flowing through the systems for prior dates of services.

Slide 13 shows another issue that's addressed in the rule and it will be of great interest to some of the specialty group members on the phone today. The ICD-9 Coordination and Maintenance Committee is responsible for updating the ICD-9 codes and the ICD-10 codes. Those are updated annually and the number of codes change. Many of the specialty groups regularly have members attend these meetings and to give their input.

Slide 14 discusses an agenda item for their next Coordination and Maintenance Committee meeting and that's for September 16 through September 17. At this meeting we will be asking the question of whether or not ICD-10 and ICD-9 codes should be frozen prior to implementation of ICD-10. Many have suggested that would be very helpful and that would allow providers a chance to gear up for ICD-10 if they didn't have to go through the annual updates of ICD-9 for a period of time prior to that. Also, educational materials could be written and developed in advance. Some people are suggesting there should be no updates on October 1, 2012. Others perhaps believe - there should be no update - the freeze should be as early as October 1, 2011. We'll be asking the public at the Coordination and Maintenance Committee to give us their views on that and to follow up with those views in writing. After we get that information, we would then take a proposal to the IPPS proposed rulemaking process and we would propose formally through rulemaking when or if a freeze for these codes should happen. And we would be very interested in hearing feedback from the specialty groups on your views on this. We'll be posting an agenda and registration information for this September 2009 meeting about a month in advance. And also you could begin registering for that meeting beginning August 14 - on or after August 14. And I've provided

on Slide 14 information where you can read about the Coordination and Maintenance Committee.

Slide 15 just shows some information that we have on our website. Ann discussed some of these earlier. We have the ICD-10 general page - it's the first bullet - which has complete coding systems, the ICD-10-CM and PCS, the mapping between the coding systems, User Guides - a lot of helpful information. The second bullet has some ICD-10 educational resources - some fact sheets, some of which are quoted on today's materials. But you may want to go and look at those fact sheets. They are very helpful. And the last part is the outreach calls like we're having today. If you've missed some of the earlier calls, such as the one on mappings between ICD-9 and 10, you may want to go to that - those - sites and listen to some of the prior outreach calls. And that's all I have for you today. Thank you, Ann.

Ann Palmer: Thanks. Donna Pickett, who is Medical Systems Administrator - I'm sorry, Dara?

Operator: Yes, ma'am?

Ann Palmer: Could you please put that line on mute?

Operator: Okay.

Ann Palmer: That we can hear in the background? Thank you. Donna Pickett, who is the Medical Systems Administrator at the CDC, is going to discuss specialty group involvement in development of ICD-10-CM, ICD-10-CM code structure, and CDC's web resources.

Donna Pickett: Thank you, Ann. ICD-10-CM is a Clinical Modification of the World Health Organization's ICD-10. ICD-10-CM was developed with - in consultation with - many physician groups, clinical coders, and other users of ICD-9-CM. We also benefited in the review of materials from prior Coordination and Maintenance Committee recommendations that could not be incorporated into ICD-9-CM due to its space limitations. As was noted earlier, ICD-10-CM and ICD-10-PCS are not in use at this time. And though not in use at this time in the United States, concepts from ICD-10-CM have been incorporated into Clinical Modifications that are currently used in other countries. Some of the modifications in ICD-10-CM have also been implemented in the WHO version of ICD-10.

In Slides 18 and 19, you'll find a partial list of the consultants and reviewers that worked with the CDC in the development of ICD-10-CM. Specifically, as noted in Slide 18, we worked very closely with the American Diabetes Association to improve the diabetes codes, to make improvements over the ones - the code structure - that we had in ICD-9-CM, which many found to be quite outdated and antiquated. We also worked with the American Psychiatric Association to make sure that Chapter 5 of ICD-10-CM was harmonized with DSM IV codes. We also worked closely with the American Academy of Neurology for the neurology enhancements.

And as shown in Slide 19, modifications for the musculoskeletal chapter were done in consultation with the American Academy of Orthopedic Surgeons. And there are expansions in the knowledge and the perinatal chapters that were developed in consultation with the American Academy of Pediatrics. And modifications to the obstetrics and gynecological chapter were done in conjunction with ACOG, specifically adding trimester information to the obstetrics chapter.

Some of the major modifications in ICD-10-CM include expanded codes and, again, for diabetes - reasons for health encounters and other factors influencing health. We've added extensions for injuries and external causes of injury. And laterality has also been added to the classification in certain segments. Just by way of example, in ICD-9-CM, the concept of open wound includes lacerations with or without mention of foreign body or traumatic amputation. It also includes puncture wounds with or without foreign body and animal bites. In ICD-10-CM, each of those concepts is now separately identifiable.

Continuing on with other major modifications, there are more combination codes for diagnoses and related symptoms. We are now using full code titles to make the meaning of the particular code much more clear. And even with all of the expansions that have been made in ICD-10-CM, there are still NOS - not otherwise specified codes - included in the classification. So if there is no additional documentation that can be used, there's still an NOS code that can be assigned.

There will be ongoing updates to ICD-10-CM. Basically those updates relate to new concepts that have been added to ICD-9-CM from the annual update process that Pat described earlier and also new concepts that have been added to ICD-10 by WHO, which also has an annual update process.

Moving on to Slide 23, let's talk about the structural differences between ICD-9-CM diagnosis codes and ICD-10-CM. As many of you already know, ICD-9-CM has 3 to 5 digits. Chapters 1 through 17 - all characters are numeric. With supplemental chapters - the E and the V codes - the first digit is alpha and the remainder are numeric. And

included in Slide 23 are some common examples of the code structure for ICD-9-CM.

For ICD-10-CM, the digits are either 3, up to 7 digits. And some examples are included in Slide 24.

In Slide 25, again, ICD-10-CM has 3 digits. The first digit is alpha. And it's letters A through Z except for U. And the alpha characters are not case sensitive. Digit number 2 is numeric and digits 3 through 7 are, again, alpha but not case sensitive or numeric.

Slide 26 provides links to the CDC web resources. We do have a page for general information related to ICD-10-CM as well as ICD-10 - the WHO version. And, also, we have links to our ICD-10-CM files, the tabular list, the alphabetic index, and the General Equivalence Maps between ICD-10-CM and ICD-9-CM.

Ann Palmer: Thanks, Donna. Dr. Lee Hilborne, who is the Medical Director, Care Coordination at the UCLA Health System and Health - I'm sorry - Health Services Researcher at the RAND Corporation, is going to provide perspectives on ICD-10 and its significance. Go ahead, Dr. Hilborne.

Lee Hilborne: All right. Thanks, Ann. Good morning or good afternoon to people on the call depending on where you are. I just wanted to spend a couple minutes talking to you from my perspective as both a practicing physician as well as a researcher and individual who works very closely with our coding team and our medical records team at UCLA and also on the national scene to some extent.

So on Slide 28, I'd just point out that having worked in the area now for a number of years that it's clear that the current situation is not sustainable. I remember hearing this, frankly, when I got into this some 15 or more years ago. ICD-9 simply is not sufficiently robust to serve the health care needs of the future. And, in reality, most developed countries have already made the transition. The number of codes is limited and the structure is just way too restrictive for the kinds of practices and the activities that we do today. And so we really need better data to drive the kinds of changes that are needed in health care and a better system really to gather and analyze the data.

We'll move on now to Slide 20 - I'm losing my numbers here - 29. In terms of working together, we need to achieve buy-in. And, in reality, physicians are already included in specialty groups' preparation tools so the notion of engaging physicians certainly was there from the get-go. And I think everybody appreciates how important it is that we are part of this transition. And that in terms of thinking about engaging physicians, the way I look at it is - we really need to focus on physicians and their groups that represent them because many of the physicians really are members of medical staffs, they're members of medical groups, the medical professional societies, et cetera. And really a multifaceted approach is critical for achieving what we're looking for. And if one looks at the overall implementation goals that are described by AHIMA and others that, in fact, the goals are equally applicable to physicians: assessing the impact, determining strategy, our information systems, educating of coding professionals. But then, also, education of physicians and clearly the opportunity for physicians to work together with coding professionals to assure that the documentation we provide is something that then can be picked up and used.

On Slide 30, I talk a little bit more about working together to achieve success. And I think that the overall thought here is that we're already in the same boat most of the time. The transition - the decision to move to ICD-10 - is a done deal; as was said earlier that the implementation date has been set. And so while we're in the same boat, what we really need to do is be paddling in the same direction. And to achieve that, we really need to have synergy of goals and expectations. We need to work together to benefit from the changes because there really are opportunities. And through that, we should be able to together survive the transition.

On Slide 31, I think that probably the first thing that we'll hear from - I hear from - many of my colleagues that it doesn't appear to be broken, so why should we fix it? And so there will be some significant engagement challenges. It really does not appear, at least from many physicians' standpoints, that the system is broken. But they're not working in the background really trying to use these data and coordinate their use as much as some of the other people in the health care team are. So it's really about engaging physicians as successful partners in making the transition to ICD-10. And I think that if we work with physicians, physicians will understand the needs, then they'll - come around - come along.

On Slide 32, I ask the question - well, what generates the pushback? Certainly the biggest thing is the perceptions regarding the impact on practice management that the general office staff lacks sufficient expertise to be able to make the transition. There may be a requirement - an increased requirement - for certified coders. And current coders in practices may need to recertify. These could be costly in many different ways. And then, also, the costly investment in new infrastructure, new information technology tools that'll be required,

new billing and collections systems that are required. And then the limited resources that we're all seeing in our practices associated with the ability to provide the necessary training.

And then on Slide 33, the impact on reimbursement that if there is - if there are - problems with coding and accuracy that there may be some decreased reimbursement. And then also during that transition, if it's not done efficiently, that there may be challenges to productivity. And then, lastly, physician practice changes that to the extent that ICD-10 has more detail in it and the ability to code at a greater depth that then the medical records documentation will be needed to support those more detailed codes.

But on Slide 34, the reality is that we must make the transition. It needs to be done for some of the reasons that I and others have already discussed and that the administration has made the decision to move forward. So we really need to make that transition rather than find reasons to oppose it. And in reality, professional societies are already studying how to make that transition happen for physicians. And I include a quote here from the American Medical Association: Looking forward to the future, the AMA is committed to providing you with the tools you need to prepare for this exciting challenge. So the AMA has already said that this challenge is going to be exciting, so we have an opportunity to do something, hopefully, that's exciting.

On Slide 35, a couple of generalizations about physicians - I think it's fair to say that, at least for the most part, physicians are smart, that they want to do the right thing. And, as I pointed out before, with appropriate data, they change what they do. And we've seen that, certainly, with clinical practice guidelines and other kinds of issues. And so I think that this will be the same here. What we need to do is

really - there's changing education approaches in terms of working together as part of a health care team rather than individuals. And certainly our health information management colleagues are part - a very critical and important part - of that team. And that in terms of harnessing information technology, which will be important in making this, recently-trained physicians in particular really do appreciate the value of IT. And, in fact, they're becoming increasingly dependent on it just for health care, but virtually everything else we do. The iPhone generation is upon us.

On Slide 36, I think I want to talk just a minute about bringing physicians along on this journey and what we need to do. I think what we need to do - we need to provide the evidence it simplifies the process. It's not that hard and it's not that onerous to work with organized medicine - many of you who are on the call - to really deliver that message. And then partner with key professions that can help facilitate the training, including our HIM professionals, where we can leverage existing relationships with those professionals and physicians. We have certainly, in our organization, a very good relationship with our - between our - physician group and our HIM professionals.

On Slide 37, really the task is not as huge as it appears. Although the coding book is huge, any physician practice really only uses a very small subset of the diagnoses that are there. And then we can work with physicians to develop crosswalks between ICD-9 and ICD-10 codes that they specifically use. And as was pointed out earlier, there is a crosswalk and the crosswalks are being refined to provide that transition between 9 and 10. I think the important thing really is to begin discussions now to reduce anxiety, but train later because really actual training needs to be just in time. If we do it now, it's going to be

a little bit too early and people will forget what they've learned. And then training should have a general focus about the importance of doing this and then, more importantly, a practice-specific approach.

On Slide 38, I just conclude by saying that really we need to work with organized medicine. Organized medicine is really already onboard. The AMA is - needs to be - a key partner. Certainly as the owner of the physician coding side, CPT, there needs to be those links.
And then, also, the Physician Consortium for Performance Improvement measures links to the diagnostic codes. And those will need to be updated for ICD-10. And specialty societies certainly will help with the specifics in terms of coding tools that are specialty-specific - the crosswalking codes, and the data for analysis, and then targeted training of members and staff. So I think I look forward to this with our professional association. I am immediate past President of the American Society for Clinical Pathology, but I think that all of us really do need to work together. And, actually, there should be some opportunities to work also across specialty societies. So with that, I'll turn it back and look forward to the discussion that follows.

Ann Palmer: Thank you, Dr. Hilborne. Deborah Grider, who is Vice President, Strategic Development at AAPC, will now discuss implementation issues for small and small group practices and AAPC's resources.

Deborah Grider: Thank you, Ann. First of all, I would like to talk about some of the fiction and facts of ICD-10 - some things that are being shared in the industry that are true and that are not true. And in Slide 40, I identify some of the benefits of ICD-9-CM which include better profiling for more specificity of data that we collect, improved clinical information for research, with clearer code choices, and higher levels of specificity. We will probably realize clearer reimbursement guidelines and,

ultimately, fewer denials. Some of the things that are not true that are being shared in the industry are:

- Physicians will need to change how they practice medicine. They will not - need to have - need to change how they practice medicine because every physician should currently document complete and accurate information to support specificity in his or her coding.
- Physicians and coders need to start learning the new code sets now, which at this point in time we would forget the codes - the actual code sets - by 2013 if we start now. And for a small physician practice, six to eight months is really appropriate timing.
- They must implement an electronic medical record. Based on the stimulus plan, it's recommended but it is not mandated to implement electronic medical records.
- And that they must hire additional staff to handle the workload, which is entirely untrue.

So how can a solo practitioner or a small private practice group plan for implementation? Slide 41 identifies the fact that we need to take a step-by-step approach, enlist the help from our managers within the practice, our coders, our billing staff. And make sure that we develop early planning ongoingly right now to make that smooth transition. And, as it has been stated many times, that there is no anticipated delay in implementation. Now, ICD-10 implementation can be accomplished with a small group or a small practitioner in about 12 steps using a team approach.

Slide 42 identifies the 12-step process:

- The first step is organizing the implementation effort.
- Then establishing a communication plan.

- Conducting an impact analysis.
- Contacting your system vendors.
- And estimating your budget.
- Documenting and putting down on paper your implementation plan.
- Developing your training plan.
- Analyzing your business process within your organization.
- Providing education and training.
- Any policy change development.
- Deployment of the code - that's when we deploy the codes to go live.
- And then ongoing after implementation - implementation compliance.

So how do we begin? Slide 43 - we organize the implementation efforts. And the first thing that needs to happen is we have to enlist a staff person - whether it be the manager, the coder, the billing person, or another physician within that practice to oversee the implementation effort. And that person will become the key point person to prepare all the information and share it with other providers and staff, to identify the work and the scope for the implementation. And, again, this should be a team effort involving everyone in the medical practice. The point person should, first of all, review the ICD-10-CM Rule if they haven't done that initially. And they should be responsible for addressing key issues, and formulating the plan for implementation, and preparing briefing materials for the providers and staff related to the work and the scope of work that needs to be accomplished. And this should be started right now.

In Slide 44, we need to look at all of the areas that will impact a practice and identify each one that will be affected. So, for example,

your practice management system, maybe your appointment scheduling system, your electronic health record (if you're using one), looking at your superbills, and your clinical areas, your IT systems, and your documentation, and other areas. And if you're using a consultant, you need to get the consultant involved in assisting with the implementation because they can bring a lot of resources and support. The providers all have to be onboard, so we have to get the support from our providers. And talk with them about ICD-10 and the impact - and how it will affect the practice, and who has that decision-making authority, and establish a timeline, and regular schedules to report that progress.

The next step, on Slide 45, is establishing the communication plan - how will we communicate with other members within the organization? And most small practices can communicate via meetings, memos, sometimes e-mails so you don't really need to change your method of communication. But you need to develop a regular schedule, maybe monthly until six months prior to implementation and then bi-weekly thereafter or maybe even weekly. And include information in publications - articles - that you find that will be helpful to enhance the understanding of ICD-10.

Slide 46 - the next step is to conduct the impact analysis. And this step should be taken prior to development of the budget, which is an in-depth look at the resources required for implementation, what costs might be involved, what systems are affected, and what hardware. And electronic medical records - if you're planning on implementing an electronic medical record prior to implementation or doing that simultaneously - that would be a time to take a look at that.

Slide 47 - you should develop a reasonable timeline so you can accomplish this in a solo or a small practice. One good rule of thumb is to map out a project plan on a simple Excel spreadsheet with benchmarks and the status of everything that's been completed and share that with the other physicians in the group. Or if you're a solo practitioner the manager, or the coder, or the billing staff can share that with the physician as the progress is moving forward. You need to review some of the mapping and crosswalking between some of the codes that you use routinely - looking at maybe your superbills and removing some of the codes that you no longer use or some of the codes that aren't used routinely, identify any new processes needed because of ICD-10-CM, any quality efforts needed to ensure proper coding specificity, and then review some opportunities that could impact reimbursement such as value-based purchasing or pay-for-performance.

And Slide 48 is an example of a simple sample project plan for implementation using an Excel spreadsheet. And you can use other mechanisms, if you choose.

On Slide 49, conducting an impact analysis. One thing I must say that coding and documentation go hand in hand. And it's based on complete and accurate documentation. And ICD-10 should impact documentation as physicians are required to support medical necessity. And it will not change the way we practice medicine, as I said earlier. However, we have to review documentation to make sure that documentation with ICD-10 will be supported when we transition to I-10. So we have to look at issues related to inconsistent, missing, conflicting, or unclear documentation. And those should be resolved early on both today with ICD-9-CM coding as well as in the future with ICD-10-CM coding. So if providers are not documenting concisely for

reimbursement today, they are currently putting themselves at unnecessary risk for not supporting medical necessity. The one thing that you can do that will be helpful is conduct periodic coding audits, paying special attention to the documentation of the diagnosis and the specificity documented in the medical records.

The next step, you'll realize in Slide 50, is contacting your system vendors. One - the first thing that you need to ask your vendors early on is will they be able to accommodate the need to move to ICD-10-CM? And will they be ready for 5010 - the Version 5010 for the electronic transactions - on January 1, 2012? Determine if your vendor will support the changes and the timeline for implementation of the changes. And try to find out what cost would be involved with transition to 5010 as well as ICD-10-CM and that will help you with your budgeting process. Find out what plans they have in place for implementation - when they will have the software available for testing. And will we need new hardware or is the current hardware sufficient based on your specific needs within the practice? Some things to consider are, for example, system upgrades. We will be using ICD-9-CM and ICD-10-CM concurrently because we will have old claims prior to October 1, 2013 that need to be resolved. So we will be using dual systems for a little while until those claims have been either paid or resolved. Looking at your hardware, your scheduling systems, your billing and practice management systems, your financial analysis software, and your electronic health records are identifying issues that vendors need to identify with your medical practice.

The next step, in Slide 51, is sitting down and formalizing and estimating your budget. So your budget considerations should include your hardware costs, any software cost or upgrades, your license cost for software, any hardware procurement, your developmental cost,

your implementation and deployment cost, possibly moving to the electronic health record. And what about staff training cost? You need to look at your coding staff. Will your clinical staff need some training? What about the financial staff, your coders, your revenue staff, your administrative staff, physicians? And identify those specific costs - looking at things like overtime costs, either pre- or post-implementation. You might have some additional costs that are incurred when you have staff out of the office while they're training, any workflow process changes, system testing. And communicate that budget plan with the appropriate management or the appropriate physicians. And then developing the ongoing budget reassessment process and that means you need to pull that budget out within a timeframe of about every six months and review and update it because it will change. And by developing the budget early on, you'll be able to spread those costs over the three-year period of time or three-, three-and-a-half, four-year period of time.

Once you've completed those steps, it's now time to begin the implementation planning. And that begins on Slide 52. And this is actually planning for how the project will be implemented by your practice. And you need to break down the implementations into stages - what gets implemented when and by whom it gets implemented. And some of your implementation may overlap such as your education, your budget development, your testing of your systems, and your actual deployment. So by beginning early on - no later than early 2010 - you need to break down that planning. Review your superbills and remove those rarely-used codes. Develop some crosswalks between the common codes from I-9 to I-10. And the GEMs files - the General Equivalent Mapping files - are a useful tool in doing a comparison. And then develop a reasonable timeline that you can accomplish this in your small medical practice or in the solo medical practice. And you -

managers and coders - should get physician approval and the physician buy-in if they are working on this project with the physicians.

And then Slide 53, I've identified in Slide 53 and Slide 54 some examples of some mapping and crosswalks. The first one is iron deficiency anemia. And that is 280 in our ICD-9-CM coding with our fourth digit identifying the level of specificity. And then with ICD-10, it's D50. And the 280.9 maps to D50.9, which is the unspecified iron deficiency anemia. So you can see the crosswalk example where that can be realized and transferred onto a superbill if you choose to.

And then next example - on Slide 54 - is your hypertension crosswalk, which is 401 in ICD-9-CM. And our fifth digit identifies the type of hypertension and 401.9 is our unspecified hypertension, whereas in ICD-10-CM we have one code - which is I10 - to identify the type of hypertension or to identify hypertension.

The next step is to develop a training plan and you'll see this in Slide 55. And you first need to identify who needs the training. The physicians obviously need training on ICD-10-CM. Your coders, your billing staff, your administrative staff, your clinical staff - everyone needs to have an understanding - depending on their role in the medical practice will depend on how much training they will need. You need to identify the needs. Whether you use an external training source. What training materials are available? And there are a wide range of different materials from many organizations that are available now currently and will be available in the future. And identify any internal resources available to support training. And you need to coordinate the internal training, identify the staff who need training in two phases. And - the AAPC or - we are recommending that you split it up into two phases. So phase one might be an overview of the ICD-10-

CM guidelines - the format and structure of ICD-10. And then later on, phase two training would be more in-depth based on your specialty - so it would be specialty-specific.

Slide number 56 - as well as developing the training plan, you need to review mechanisms for training. And there are many mechanisms that will be available such as distance learning or e-learning, workshops, audio conferences, webinars, books, and as well as other conferences, national conferences from various organizations, and specialty societies will probably offer training as well. So you identify what type of training mechanisms you will employ and then determine if temporary staff or overtime will be necessary during that training period. And develop a communication plan for your staff on the status of the training - who gets trained when. And make sure it occurs in a scheduled timeframe - where it's appropriate, where you don't have too many people out of the office at one time.

The next step, looking at Slide 58, is analyzing your business processes. And this is identifying all your systems and processes within your office that are currently using ICD-9-CM. And reviewing existing medical policies related to ICD-9-CM. And find out which contracts are tied to your reimbursement based on a particular diagnosis. And as the insurance carriers and the health plans develop new medical policies, modify any of your contract agreements with some of your health plans, if it's applicable. So you need to conduct an assessment of needed changes along with a detailed review of the medical practice to determine your usage. Identify your systems and processes - your clinical systems which include maybe your laboratory and radiology services, your practice management, and your registration process, your computerized systems, your superbills, any other reporting that you do - whether it be quality or public health

reporting. And then identify the limitations in the current use of ICD-9, realizing that not all diagnosis codes are allowed by health plans. Look at auditing your clinical documentation, reviewing your specific clinical events or adverse events. And then when you're looking at your health plan contracts, contact your payers and discuss potential changes to existing contracts, determine the timing of contract negotiations, and modify any agreements. And communicate your contract changes to the appropriate staff, which is very important. And then one thing that - medical - any medical practice can do is conduct a gap analysis to determine areas that you can make changes and improvements as you go through this transition process.

The next step, on Slide 59, is the actual education and training implementation process. And this is when training should begin. And as I stated early on, education and training should begin approximately six to eight months. And it depends on how many staff you have to get trained because you don't want too many staff out of the office at one given time so business can continue and physicians can still - practicing - practice medicine. Larger practices, of course, may need to begin earlier because they have a lot - of - more staff to accommodate. Look at the various methods of training and how people learn. And, again, the training time depends on the role in the role in the medical practice. A medical coder might need more training than maybe a clinical staff person. And a physician might need - more coder - more coding training than a clinical staff person. So make sure that you identify everyone that needs training such as the coding and billing staff, physicians and other practitioners, your administrative and managerial staff as well.

And then turning to Slide 60, policy change development. After your health plans have completed and changed their medical policy for

procedures and services, it's a good idea to review those new payment policies. Make sure that you share those with the billing staff, and the coding staff, and it may even affect the front office staff. So you need to make sure that everybody reviews those policies that would be affected in the medical practice and communicate those policy changes. And you want to wait to begin this process after the insurance carriers develop their ongoing revision of their medical payment policies.

The next step, in Slide 61, is deployment of codes. And this is the step when the vendors deliver the software update with ICD-10-CM and the ICD-9-CM. They will do the ICD-10 to the ICD-9 to ICD-10 mapping, and then the mapping forward and backward from ICD-10 to ICD-9. And they will install the software updates on the medical practice system. And the system has to be tested more than once to ensure delivery of claims on the go-live date. So the vendors should be testing the systems; integrating the software into your medical practice systems; making any internal customizations that you might need; testing the systems with either clearinghouses, electronic claims transmissions, with other payers. And it should be done end-to-end. And ensure that the vendor will maintain updates to the code sets during the transition.

And then, lastly, implementation compliance. And our compliance date is October 1, 2013. We need to, first of all, prior to and after implementation - if you employ coders - measure their productivity when using ICD-9-CM and reevaluate the medical record documentation to ensure that ICD-10-CM coding can be achieved at the highest level of specificity. Make sure that you perform your internal testing of your coding and billing in ICD-10. Provide additional education and training if deficiencies are identified. And the post-

implementation - you need to monitor compliance activity to identify any problem areas, probably for several months up to a year or so. And that would be resolving any claim errors or denials, re-reviewing insurance carrier payment policy as they revise or make changes. And then conduct a medical records documentation reassessment periodically which you should be doing based on compliance - medical record coding documentation audits to ensure that the correct procedure and diagnosis codes are submitted to the carrier, and that you were paid correctly.

So Slide 63 - the American Academy of Professional Coders - what we are developing for our education and outreach resources. And we have a lot of exciting things that we're working on. The first thing that we're working on right now and we have completed - we are offering three free webinar series on ICD-10 implementation on July 16, July 23, and July 30. And if you cannot attend, it will be available for download free on our website. We're also offering, which I'm very excited - that - about - 15-minute webinar series for physicians and managers. So we're developing 15-minute webinars, 15 different topics. And we will have those available the first quarter of 2012. And the reason why we decided to develop 15-minute webinars - because we realize that physicians don't have much time during their day when they're trying to see patients and trying to manage the business - their practice - that they don't have time to devote to spend for an hour at any given time. So 15 minutes is short and we're developing several topics. We're also developing onsite provider three-day curriculum for medical practices, typically for the medium to large group medical practice or universities. And this will be three days onsite and it will be trained by our ICD-10 dedicated team of expert instructors that have been selected by the AAPC to train our curriculum, to conduct our webinars, our distance learning, and our conferences. So these people that we have selected

will be consistent and they will be traveling all over the country providing education. We've also developed some distance learning webinars. First of all, we're starting out with distance learning on general ICD-10 guidance, format, and structure which will be rolled out in 2010 during the first quarter. And then we are going to develop - or we have started developing - special specific coding training webinars as well as distance learning modules for various specialties. So we'll have a distance learning webinars available for, for example, for cardiology, for orthopedics, et cetera. And we're also developing half-day workshops on ICD-10-CM which are three-hour workshops for your coders, your billers, physicians, and staff to attend to learn more about implementation. We're also offering education sessions - 5 to 10 sessions at the AAPC national conference in 2010 and 10 sessions in 2011. And in 2012 and '13, we have 20 sessions available on just various topics on ICD-10-CM implementation and training. And then in 2013, we are launching across the country eight regional conferences dedicated on ICD-10 topics alone taught by our instructors as well as offering in our Coding Edge articles and information on our website.

So, lastly, to share with you with our AAPC plan for our certified coders - all of our certified coders do not need to be recertified. And there's been some chatter in the industry that they do. They do not need to be recertified. But we want to ensure that our coders are ready to use ICD-10-CM on October 1, 2013 so we have developed an ICD-10-CM proficiency test - beginning October 1, 2012 that will be available. And they have until September 30, 2014 to take this exam. And they must pass this proficiency exam to maintain their certification. It is online, it's a timed test, 75 question, open book so they can use resources available to them. And it's going to be at a low cost - $60 for the exam. And that includes the ability to take the exam twice.

So in closing, I'd just like to share with you a prescription for success that I feel is important. So the time is to begin now on ICD-10 planning. Get your key point person or your task force together to begin the steps to implementation, get support for implementation with the providers, develop the communication plan and communicate with providers and staff routinely, conduct your impact analysis and identify how ICD-10 affects your practice, contact your system vendors for help and assistance early on, and develop your training plan to ensure all appropriate staff receive training at the right time and the right mechanism, develop your implementation plan internally, ensure your staff are training on your specialty-specific codes and guidelines, review your policies and make internal changes, and conduct an outcomes measurement before you go live, making sure your vendors install the updates and test your systems prior to implementation, and maintain your compliance beyond the go-live date. And, lastly, monitor coding and documentation for compliance on a regular basis and keep on top of denials and policy changes from health plans as they occur.

Ann Palmer: Thank you, Deb. Sue Bowman, who is the Director, Coding Policy and Compliance at AHIMA, is going to discuss implementation issues for larger group practices and how specialty groups can prepare their members for ICD-10 as well as AHIMA's resources.

Sue Bowman: Thank you, Ann. I'm now on Slide 66. As has been mentioned earlier, there are a number of ICD-10-CM benefits for physician practices. Medical terminology and the classification of diseases have been updated to be consistent with current clinical practice. And since many medical specialty societies were involved in the expansion of codes pertaining to their specialty areas, ICD-10-CM codes may be easier than 9-CM codes for physician practices to use. The transition to ICD-10 presents both opportunities and challenges. And sometimes we

hear a little bit more about the challenges than we do the opportunities, but there are a number of opportunities:

- First of all, one opportunity is more accurate payment as well as improved patient safety and better patient outcomes due to better data.
- Another opportunity is improved clinical documentation and coding accuracy, which will in turn improve patient safety monitoring, compliance measurement, and compliance with reimbursement rules and regulations.
- We also anticipate improved efficiencies and lowered costs and administrative functions including increased use of automated tools to facilitate the coding process which will lead to increased productivity, fewer staff requirements, and relief of the coder shortage.
- We also anticipate decreased claims submission and claims adjudication costs; fewer rejected claims, resubmitted claims, and payment errors due to fewer coding errors; decreased need for manual review of medical records to meet the information needs of payers, researchers, and other data-mining purposes; improved resource management; reduced labor costs; and increased productivity.
- Also, because of the specificity and detail in the ICD-10-CM codes, a reduction in requests for additional documentation to support claims is anticipated. ICD-10-CM contains the detail necessary to demonstrate acuity and eliminate many post-billing questions related to evaluation and management codes, quality measurements, and other issues that cause significant administrative time and resubmissions as well as delayed reimbursement.

- And, also, because of this increased specificity and detail, we expect that the codes will provide better support of the medical necessity of the services that had been provided.

I encourage you to start now to get ready for ICD-10 implementation. The fact that physician practices only have to transition to ICD-10-CM and not ICD-10-PCS makes it easier to make the conversion, but there's still a lot of work to be done. The ICD-10 transition should not be viewed as merely an IT project but as an opportunity to develop a strategic plan to improved systems and, hence, increased revenue by streamlining processes, improving systems, and increasing efficiency.

The phases of an implementation plan are:

- The first phase is impact assessment, which is the phase I'm going to focus on today but it's only the start. The seven steps to the impact assessment phase are listed on Slide 67.
- The next phase is preparing for implementation. And this would also include making the changes to Version 5010 of the electronic transaction standards.
- Phase 3 would be go-live preparation. And this phase is focused on testing and training - certainly a very busy time period.
- And, of course, we can't forget the post-implementation phase. We won't be entirely done on October 1, 2013 - we will still need to conduct careful data review and analysis to see where we're at and correct any problems that have been identified.

But today we're going to concentrate on the first phase - the impact assessment - which is divided into these seven steps that I've listed here. AHIMA's ICD-10 preparation checklist includes greater details for each phase. And this document is a great resource to get you started. It can be customized for any type or size of health care entity. It is a

free resource and can be accessed from the ICD-10 page on the AHIMA website.

- The first stage of preparation in the impact assessment phase involves developing a strategy on how to proceed by identifying key tasks and objectives. As one of the first steps, it is suggested that you establish an interdisciplinary planning team to oversee ICD-10 implementation and develop an implementation strategy for the practice. A leader of the planning team should be designated as well as a physician champion of the ICD-10 project. Next, an internal timeline should be developed, including the resources that are going to be required for each step in the timeline. Responsibilities can be divided among team members so that everyone shares the work such as the coder training, physician training, and IT upgrade issues. This planning phase represents an opportunity to reassess and refine your current operations. You can learn a great deal about your current coding process, clinical documentation improvement plans, and so forth. And when developing an ICD-10 implementation plan, don't forget to factor in other initiatives that are going on at the same time such as EHR implementation or any changes that come out of health care reform. What can be done in parallel? What sequence of activities makes the most sense in terms of being the most cost-effective and eliminating rework or wasted efforts?
- On Slide 69, we move into the communications step. You need to build awareness of the ICD-10 transition by orienting key personnel throughout the practice. All personnel need a basic familiarity with the structure, organization, and unique features of the new code set. You need to provide people who will be affected by this change an understanding of how the new system fits into internal and external transitions including

electronic health records, health information exchange, and health reform. You need to provide people with an understanding of how your implementation strategy fits with the environment at your practice. For example, adoption of electronic health records and interoperable health information exchange require improved classification systems for summarizing and reporting data but not everybody understands the key link between EHR adoption and moving to a better coding system. All users of ICD-9 data need to understand how the transition to ICD-10 is going to impact their current work and processes. Ongoing communication is key to successful implementation. So a communication channel such as a newsletter or intranet site should be developed to keep people informed as to your implementation plan, and what progress has been made, and where you are on the timeline.

- Next you'll need to address the practice's readiness for ICD-10 and other changes going on now or anticipated between now and ICD-10 implementation. During this impact assessment, consider things like the affected staff - meaning both clinical and administrative staff. Information systems - the affected systems, applications, and databases. Documentation process and workflow - do you know all of the places where ICD-9 comes and goes and where it used? Look at your data availability and use - both what you do now and your future plans. Look at your current plans and acquisitions. And look at both your organizational and vendor capacity and other key projects that will occur during this same transition time period.
- On Slide 71 - listed some of the potential systems that large physician practices may have that could be impacted by the transition to ICD-10. As you can see, it's quite a few so one of the steps in this impact assessment phase is to perform a

comprehensive systems audit. Inventory all your databases and systems to see where ICD-9 codes are used. Look at all your screens and input devices. Map your electronic data flow to inventory all the databases, systems, applications, and reports that contain ICD-9-CM codes. Give consideration to: do you use application service provider, or an internally-developed system interface, or other affected software programs? How are ICD-9-CM codes used in each system? Will ICD-10-CM codes serve the same purpose and will a change in the coding system impact the results? Where do the codes come from? Are they manually entered versus imported from another system? How is the quality of data check? Look at the interfaces between systems and identify new or upgraded hardware and software requirements and determine budgetary implications. For example, will larger computer monitors be needed or a more powerful hard drive? Don't forget about EHR systems. Many of them have ICD-9-CM codes embedded in them. It's time to start talking to your vendors - this is a key step that needs to be done as soon as possible and will require regular, ongoing communication. Determine what their readiness is and what their timeline is for making the ICD-10-CM upgrade in their products. When will the upgrade be ready? Try to get their status report in writing. Is the upgrade covered by an existing maintenance contract? If not, what will be the cost of the upgrade and when will it be incurred? What is the anticipated timeline for testing the performance of ICD-10-CM in the practice's systems environment? Consider new contracts as well as contract renewals. Also look at systems currently under consideration or in the process of being purchased. Are they going to be able to accommodate the ICD-10-CM codes? Make

sure if you're purchasing any systems between now and implementation that they are ICD-10 ready.

- Next on Slide 72, it's time to start assessing the educational needs. You need to identify the people who will need education. And this isn't just the coders. It's the physicians. Anyone who uses ICD-9-CM codes will need some type of education, but they won't all need the same type or level of education. So you will need to decide what type and level of education each group of individuals will need. For example, coders will obviously need to increase their knowledge of the new coding system. And have an understanding of the structure, organization, and the unique features and start gaining a moderate level of familiarity. And physicians will need to understand the requirements for documentation. Training for physician practice coders that work in a particular medical specialty area can be focused on the subset of codes most commonly used by that practice. Determine whether education is going to be provided internally, externally, or both. And what media will be utilized. There will be all kinds of ways to get ICD-10 training - whether it's through traditional face-to-face classroom teaching, which can be expensive because then there's associated travel costs. There will be audio conferences, CD-based training, downloadable materials through self-directed learning, or various forms of web-based instructions which may be self-directed or instructor-led. The timing of education for different groups of people within the practice will need to be determined as they will need education at different times. Ideally, intensive coder training should be provided as close to the implementation date as possible. Surveys conducted by AHIMA in the past have suggested that coders don't want to be trained more than three to six months prior to implementation in order to retain what

they've learned when they actually start using ICD-10-CM. However, realistically, in order to get all of the coders trained, many providers with large numbers of coders may need to start providing this training a little earlier - say about six to nine months prior to implementation. But as practices start planning their overall implementation strategy and determine when and how their coders will be trained in ICD-10-CM, I recommend that the issue of knowledge retention be factored into the decision so that training is not provided too early. Training too early will result in higher costs because the coders may need retraining or there may be a higher coding error rate at the beginning. This is not to say that coders shouldn't start now to become familiar with the structure of ICD-10-CM and its new features, but the intensive coder training to prepare coders to use ICD-10-CM should wait until closer to implementation. One to two days of training is all that is anticipated for coders only needing to learn ICD-10-CM and not ICD-10-PCS. Coders that are very proficient in ICD-9-CM may need the lower end of that range of training simply because the structure, many of the instructional notes, and so forth in ICD-10-CM (as Donna Pickett mentioned earlier) are similar to ICD-9-CM and will seem familiar to coders. So 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 primarily need education on the changes and in the classification itself as well as definitions and guidelines. And those in specialty physician practice areas may require focused training on a certain specialty area such as OB, ENT, or cardiology.

- On Slide 74, you need to start looking at medical record documentation improvement opportunities. It's important to keep in mind that, as Donna mentioned earlier, there are still nonspecific codes available for use when documentation doesn't support a higher level of specificity. However, documentation supporting accurate and specific codes will result in higher quality data. And improved documentation is being driven by many initiatives outside of the ICD-10-CM implementation such as quality measurement reporting, value-based purchasing, and patient safety. And practices might be surprised to find that much of the detail needed to support ICD-10-CM codes is already there - it's just not being used today because it's not needed for ICD-9-CM coding. This was actually demonstrated by the American Hospital Association and AHIMA ICD-10-CM field testing project conducted a few years ago, which involved coding medical records from multiple settings including physician practices using ICD-10-CM. Consider looking at your ICD-9-CM frequency data to identify what diagnoses are most commonly coded in your practice now, learn the ICD-10-CM counterparts, and focus education on these areas first.
- On Slide 75, it's important during the impact assessment to identify the specific budgets that will be needed to cover the various costs including systems changes, and education, hardware and software upgrades, and so forth. For a period of time, it's expected that productivity and accuracy will suffer as people become more familiar with using the new coding system. A determination must be made whether there will be a need for increased staffing or consulting services to assist with IT changes, coding backlogs, monitoring of coding accuracy, or to support other aspects of implementation or testing. However, ultimately in the long term, it's expected that coding errors will

> decrease to a level below ICD-9-CM because of the more accurate clinical terms and more specific code descriptions in ICD-10-CM. The ICD-10 - excuse me - code sets lend themselves to the use of computer-assisted coding technologies better than ICD-9-CM because of the additional detail and specificity. And we expect the development of increasingly sophisticated computerized tools that will improve coding efficiency and ultimately revolutionize the coding process.The improved structure, logic, and specificity will result in greater reliance on automation to support the code reporting and claims processing functions which will lead to increased productivity and improved coding accuracy.

So on Slide 76, as I mentioned, consider the use of electronic tools to facilitate the coding process. But keep in mind that the use of ICD-10-CM is not predicated on the use of electronic hardware and software. There are code books already available and they're normal, manageable size. However, also keep in mind that electronic tools are not necessarily expensive and could really help facilitate the coding process. For example, the Federal government currently offers an ICD-9-CM CD at very low cost and I presume that they will do the same for ICD-10. Don't convert the superbills too early. Currently, ICD-10-CM is still being updated annually. As was mentioned earlier, there may be a freeze on making changes to the code set at some point prior to implementation. And that would be a good time to start working on updating the superbills. But if you do it too early, it'll just have to be done again - if changes - when changes are made to the code sets. Also consider for a small conversion project such as superbills - it's probably easier and more accurate to assign the ICD-10-CM codes directly - not to use the General Equivalence Maps that are on the CMS and NCHS websites as those are really intended for larger data

set conversions. The key to a smooth, successful transition, the least amount of cost is to start preparing early - meaning now. Make sure the right education is provided to the right people at the right time. And provide clear, ongoing communication to all personnel.

So how can specialty societies help their members prepare? Well, provide early training to selected individuals and ask them to develop specialty-specific resource materials. Compare the relevant chapters in ICD-9-CM and ICD-10-CM, identify the differences and areas where changes will most benefit the physician practice (such as support for medical necessity or faster reimbursement), and develop training materials focused on the areas of greatest benefit first. Develop lists of documentation improvement focus areas according to the degree of potential benefit. For example, in orthopedics, faster payment of motor vehicle accident claims might occur if the exact location of the injury, how the injury occurred, and whether it was initial or subsequent treatment are documented and coded.

On Slide 79, just briefly mention for those who have coders who have the AHIMA certifications - there will not be any exam requirements to maintain the certification for ICD-10, but there will be additional continuing education units required. These requirements may vary by the different AHIMA credentials that we have and what those specific - how many CEUs per credential - has not been determined yet. But the reporting timeframe for these additional CEUs will be 2013 and they will be specific to ICD-10. Currently, our CEU requirements are not specific to any particular topic but for this particular transition, the CEU requirement will be focused on ICD-10 for a certain number of required CEUs in that reporting timeframe.

On Slide 80, we've outlined a few of the resources that AHIMA has available. I already mentioned our ICD-10 preparation checklist, which can be accessed through our website. We also have an electronic ICD-10 coding newsletter, which is free. We also offer a number of webinars, which can be attended live or purchased later in an archived version format. We do have a frequently asked questions service. We do not answer the questions individually, but we select - we accept - questions at the e-mail address listed on Slide 80 and we include those questions in a list of FAQs on our ICD-10 website. We have a number of articles on ICD-10, which are all available through our website. And we have a couple of ICD-10 online courses, which we are continuing to revise and expand.

We also have a number of book products and we have Proficiency Assessments that allows practices and other health care entities to test the proficiency level of their staff in ICD-10-CM so that they can focus the education for that staff in the areas where they are weakest.
We have a number of audio seminars and also conferences - all of which more information can be obtained through our website. For future AHIMA resources, we are starting to offer an ICD-10 academy to train people who are going to be ICD-10 trainers. So this year, the ICD-10 academy is focused on both ICD-10-CM and ICD-10-PCS, but we will - we do plan to - offer academy sessions in the future that will prepare people who are only planning to do ICD-10-CM training and not ICD-10-PCS training. We are developing a pocket guide for ICD-10, which will provide access to quick facts and information about the ICD-10 code sets in an easy reference guide type of format. And we are in the process of developing an online anatomy and physiology refresher course, which will be titled, "Applications of Coding Principles Using Anatomy and Physiology." And now I would like to turn it back to Ann.

Ann Palmer: Thank you, Sue. May I please ask the individuals who are not speaking to place their phone on mute? Thank you very much. Nelly Leon-Chisen, who is the Director, Coding and Classification at AHA, is going to provide information about implementation issues for physicians in the inpatient setting and AHA's resources.

Nelly Leon-Chisen: Thank you, Ann, and good afternoon, everyone. You've already heard quite a bit of detailed information on how to prepare and implement, so what I would like to do now is share with you some thoughts and ideas because I think that for hospitals to do a successful job at implementing ICD-10, we have to work with our physicians. And so I'm very interested in ensuring that physicians are engaged in the ICD-10 implementation process because this will ensure that our members - the hospitals - also are able to implement this as they should. So we're now on Slide number 84 - one of the myths floating around during the discussion on ICD-10 was that the greater level of specificity available in ICD-10 would mean that physicians would be required to order more tests. In fact, the myth was that hospitals would require medically unnecessary tests so that coders would be able to assign the more specific codes available under ICD-10. But the reality is that no one likes medically unnecessary tests in specialty hospitals since payers do not reimburse these tests. So the implementation of ICD-10 does not require additional testing be performed in order to allow correct code selection - that would be pretty ridiculous for any code set to do that.

We're now on Slide 85. The next myth is that ICD-10 implementation will create a burden on physicians in their hospital practices in order to document more. The fact is that hospital health information management professionals and physicians have collaborated to

improve documentation for many years. And they do so for a number of reasons. And this is not just to harass the busy physician. So the important message I would like you all to carry - no, let me rephrase that - I would beg you to carry on behalf of the hospital coders, who we hear from quite often, is that you please ask your members not to shoot the coders. Hospital coders currently query physicians because coders are not allowed to diagnose patients, or to make assumptions regarding a patient's care, or to interpret clinical information - even if it is abundantly obvious to a physician where they read test findings and they can make a diagnosis. But coders - we cannot assign a code without a provider confirmation. And I'm sure physicians would really not want coders to make clinical assumptions about their own patients either.

Moving to Slide 86, there is a very strong relationship between coding and documentation. In fact, all hospital coding is based on physician documentation. This is not only supported by the existing ICD-9-CM coding guidelines, but will continue to be so in the future under ICD-10 as well. So hospital physician documentation serves many purposes and it's reviewed by many different people who are not involved in the care of that patient. The documentation is reviewed by payers, auditors, and now, more recently, with the recovery audit contractors or the RACs. We want to ensure that the documentation supports the codes that are assigned. So clear and concise documentation is important today and will continue to be so with ICD-10.

And yes, there are unspecified codes today - both in ICD-9-CM and ICD-10-CM. So if there is imprecise documentation, there are codes that can be used. So we go back to the myth that with ICD-10, you know, you would not have unspecified codes - that is not correct. However, as we all know, it is in everyone's benefit that we work

together towards better documentation for a variety of reasons. And these reasons include to avoid misinterpretation by third parties that are not involved in the care of the patient. So whether they are attorneys, payers, or anyone else - it is important that the documentation be as complete and specific as possible. Other reasons for better documentation include to justify a medical necessity and to provide a more accurate clinical picture of the quality of care provided. And as the health care field becomes more and more interested in value-based purchasing and quality reporting, it is more important than ever that there be good documentation. In addition, we can then ensure that the most specific codes can be assigned based on the good documentation since many of the emerging initiatives are looking at administrative claims data or coded data rather than performing record reviews. And as we have heard, one of the benefits of ICD-10 is that when you have better documentation, you have more specific documentation. You can capture that with ICD-10 where you may not be able to do so in ICD-9.

On Slide 88, we have a little bit of information about the AHA Central Office on ICD-9-CM. And some of you may be familiar with our Office. We were created back in 1963 through a Memorandum of Understanding with the Department of Health and Human Services. The Office is housed and supported by the AHA and it serves as a clearinghouse for issues related to the use of ICD-9-CM. We receive coding questions from all types of users and provide direct responses free of charge. So it's not just for hospitals - it's not just hospital coding. We also do hear from - directly from - specialty societies but also from individual physicians. And these questions can range from simple questions as in how do I find a fifth digit to more complex questions for new conditions or new technology where their classification doesn't readily provide guidance. So the role of the Office, then, is to maintain

the integrity of the classification system so that the codes can be applied in a uniform and consistent manner by all users. And because we get hundreds of letters every month, we quickly become aware of the shortcomings or problems and limitations of the coding system. The letters that we get can become recommendations for revisions and modifications to the current ICD-9-CM, especially after we bring those issues to the Coding Clinic Editorial Advisory Board and we're not able to find a good match with the existing codes. We also develop educational materials and programs on ICD-9-CM, including audio seminars on hot topics. And we also have a speaker's bureau. But our best-known resource is the AHA Coding Clinic for ICD-9-CM.

On Slide 89, let's talk about our future plans for ICD-10. We don't presume to be the educational source - the only source - for ICD-10 information for physicians but we do intend to support the AHA Central Office on ICD-10 as a service to address coding questions through a clearinghouse function, just like we do today. And we would continue to provide direct responses to individual coding questions. And, of course, that information would also be fed through for content into ICD-10 into a Coding Clinic publication with the collaboration of the ICD-9 Cooperating Parties, which would then become the ICD-10 Cooperating Parties. So we envision that the major functions for Coding Clinic for ICD-10 would continue to be similar to what we currently have for AHA Coding Clinic for ICD-9. And our major functions include providing official ICD-9-CM coding advice because you can rely that every question and answer has been discussed and approved by the Cooperating Parties and the Editorial Advisory Board. As part of our longtime preparations for ICD-10, since 2004 the textbook that we publish, the Faye Brown ICD-9-CM Coding Handbook, has contained preview chapters on ICD-10-CM. And because we work with hospitals, it also includes ICD-10-PCS. So,

obviously, if you were looking for information to have for people that are only working with physician practices, then you could use that textbook and ignore the sections on procedure coding. And we intend to publish an ICD-10 Coding Handbook similar to the one we currently have for ICD-9 and has been successfully used to train new coders since 1979.

We're now on Slide number 90 - Our plans include being willing to collaborate with State hospital associations and other stakeholders, including physician specialties. Again, we're willing to help where we can. We don't necessarily anticipate that we will organize or conduct any training specifically geared for physician practices only. But if anybody needs some assistance from us, we're willing to partner to provide education and outreach - just like we're doing today. And that means whether putting on joint programs such as audio seminars, or webinars, or being a speaker for someone else's program. We think that the training would vary depending on who the individual is and the function that these individuals perform, but we pretty much agree that in-depth training of coding professionals would be three to six months prior to implementation, although we are reconsidering this timeframe because we realize that there is going to be a lot of people needing training. So we may need to kind of push it back a little bit because we don't really want everything crammed towards the end - trying to do everything at the same time and having all the coders out at the same time as well. But if we do that, we agree with what the other speakers have said that there will still need to be refreshers or little tip lines that would be available - reminders so that when we're ready to go live people have not forgotten what they've learned if they've gone to training way too early. However, for folks that are looking at their information systems, trying to determine the impact of this change, trying to budget for it - we think that more general overviews earlier in

the process, even now, are probably a good idea because it may take time to even figure out what's needed. If you are working with a single system and you have a pretty small practice - there's only one or two people that need to be trained - at least you'll be able to know what do I need to do, how do I plan. But if you're working with a much larger organization, the only way you will be able to figure out what this really means for you and your practice or your organization is by at least becoming familiar with - you know - how big is this? What's the impact? And also we'd like to emphasize that there needs to be assessment that involves not only looking at what kind of training, but budget because budgeting issues are going to be a consideration considering where the economy is today. And I would urge that individuals need to consider where and how they would purchase their educational resources. We're a little concerned - we don't really want everyone to spend all their dollars in heavy-duty training today only to find out later that they have run out of money and they've used all their money way too early. So we realize that like with so many other new initiatives that providers have had to deal with, there will be many offerings. So we would want to make sure that these offerings come from sources that hospitals, and physicians, and other coding professionals have learned to trust over the years. And we have already started our educational outreach as far as ICD-10 is concerned.

And, more recently, we have developed a couple of member advisories that went out to all our hospitals. And they're also available through our website and you have the website on Slide 91. And just so you know, in our advisories, we have indicated to our CEOs that they need to share the information with their medical staff and work with our physicians. And we're developing some CEO materials that are specific to our hospital members, but we will have information on how hospitals should support physicians to ensure that they are aware of

ICD-10 and to work with them on documentation issues. So every hospital will decide at what point to engage physicians and what level of support they would like to provide, but we think that it's very important that hospitals work with their physicians to make sure that everybody is working together. There are also several presentations and articles available on our website as well. And feel free to use that material to share with your members or to develop information for your own members. We have started, for 2009, an ICD-10 implementation series of audio seminars that has been built into our regular Coding Clinic series. The first one was an introduction to ICD-10, again, not because we want people to have in-depth information but just to make them aware of what the implications are - what does this mean. The next one is on developing an implementation team. And the last one is to give listeners a taste of ICD-10 and what are the similarities and differences between the two coding systems. We don't think that people need to have in-depth ICD-10 coding yet, but we believe that periodic high level presentations can diminish the level of anxiety and fear associated with this transition. And as I had mentioned - on this last slide from me - you have two websites that you can go and visit and look for information. And in closing, we look forward to working with the hospitals' coders, working with physicians to ensure that we all have a successful implementation of ICD-10.

Ann Palmer: Thank you, Nelly. I would like to point out that rather than having an Encore presentation after today's call, we will instead be posting the transcript of the call on the ICD-10 Web Page. At this time, we will answer participants' questions regarding the topics presented during today's call. Dara, can we go ahead and start the question and answer session, please?

Operator: Absolutely. We will now open the lines for a question and answer session. To ask a question, please press star and the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Today's conference is recorded and transcribed for Encore replay purposes. So please say your name and organization prior to asking your question. And your first question comes from the line of Sharon Kinney. Your line is open.

Sharon Kinney: Thank you. This is Sharon Kinney from Dr. Robert J. Bellino's office in Bradenton, Florida. I have a question on the website. I was unable to get any of the slides (unintelligible) teleconference. And what is the website that we can get this in writing?

Ann Palmer: Unintelligible.

Sharon Kinney: I was unable to get that down.

Ann Palmer: The PowerPoint has not been posted yet on the web.

Sharon Kinney: Okay.

Ann Palmer: The - we wanted you to have the PowerPoint format in case you wanted to use it to conduct your own training.

Sharon Kinney: Okay.

Ann Palmer: So I can send that to you if you want the PowerPoint presentation.

Sharon Kinney: Okay.

Ann Palmer: I'll go ahead and give you my e-mail address. It's ann - A-N-N - dot - palmer - P-A-L-M-E-R@cms.hhs.gov. And then shortly after this call, we will post the PDF format at www.cms.hhs.gov/ICD10. And on the left side of that page, you want to go to 2009 CMS Sponsored Calls.

Sharon Kinney: Okay, great, thank you.

Ann Palmer: That's where we will go ahead and put it.

Sharon Kinney: Okay, great, thank you.

Ann Palmer: You're welcome.

Operator: And your next question comes from the line of Glenn Littenberg. Your line is open.

Glenn Littenberg: Hi, good morning. I'm a gastroenterologist in Pasadena, California, practice management committee chair for the American Society for GI Endoscopy. It looks like you're asking for a process where tremendous numbers of practices and specialty societies are all going to be trying to do some kind of practically usable mapping and asking for individual vendors to be doing mapping. You know - you - there's a generic website that has some mapping information there, but seems to me like we're doing tremendous redundant work where this might be coordinated more nationally where the same product - same tool - could be used and distributed cheaply to vendors to, you know, all users who would want it. And be able to markedly facilitate the ability of particularly small practices then to take a subset of the codes that they use every day instead of having to reinvent the wheel all over the country. Was there some discussion about doing this? Is there a way that this would be practically achievable?

Pat Brooks: This is Pat Brooks and I think I can respond to your question. We have developed a tool and we had another outreach call on this same subject on May 19, 2009. It's called the General Equivalence Mappings. And these are detailed mappings that take ICD-9 codes and gives the general ICD-10 equivalence for it. And they also give the ICD-10 code and map that to the ICD-9 codes. There's detailed information on our ICD-10 website on - we have all of the General Equivalent Mappings. We have User Guides. But it might help you to look into that May 19 outreach call on our website. You can listen to the audio and you can see the slides. Now taking that - you raised some very good points that we would encourage some specialty societies might want to look at those General Equivalent Mappings and develop some products for themselves. Most of the mapping's done - the work. Maybe you would want to take subsets of codes - GI codes or other people maybe want cardiovascular codes - and develop something for your specialty society that's just more focused. But the actual literal mappings have been done and everyone's free to take those and use them.

Glenn Littenberg: We actually have looked at them and they're relatively user non-friendly. They would take a lot of work time to put together different parts of it to make something practically usable out of it. I mean, I look at that as kind of the starting point to do something jointly that would be much more user-friendly. Again, you just - you know - we're just kind of all left on our own to take this information, but it's not easy to use. I mean, we were trying to just extract a small group of GI codes out of it to look at something and it's a lot of work.

Pat Brooks: And we appreciate your suggestion. You may want to look in our User Guide where we talk about how you could download the files that are

also there with the full titles. But I understand what you're saying that it does require additional steps to do that. But maybe the specialty societies would want to get together to decide - working with a vendor is something that would suit you more. We did make these available so that they could be used.

Sue Bowman: Pat, this is Sue. I just have a comment I could add. I am aware that there are vendors out there that are developing technological tools that can be customized for different projects - whether that be a hospital database or physician practice use - so there is work out there in developing user-friendly tools that can be purchased, I understand at a reasonable fee, that will facilitate that process so that people don't have to reinvent it all themselves. I don't know if that helps.

Operator: And your next question comes from the line of Mary Donnelly. Your line is open.

Mary Donnelly: Hi, this is Mary Donnelly with Kidney Specialists of Oklahoma City. It would be very, very beneficial for us to have the slides prior to the teleconference. I'm a visual person. I can hear words, but if I have words in place where I can make my notes on, it would be very beneficial. Thank you.

Ann Palmer: So just to let you know, this is Ann, and they were sent out in the e-mail message from Valerie Haugen of CMS some time ago. I do apologize if you didn't receive that.

Operator: And I am showing no further questions in queue at this time.

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

Operator: Thank you. And this concludes today's conference call. You may now disconnect.

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