Centers for Medicare & Medicaid Services
ICD-10-CM/PCS National Provider Call for Part A and Part B Providers
Moderator: Ann Palmer
November 12, 2008
12:30 p.m. ET

Operator: Good morning and welcome to the ICD-10-CM/PCS National Provider Conference Call for Other Part A and Part B Providers. I would now like to turn the call over to Ms. Ann Palmer. Ma'am, go ahead.

Ann Palmer: Thank you. Hello. My name is Ann Palmer, and I'll be moderating today's ICD-10-CM/PCS conference call. Please note that this call is being recorded and will be transcribed. The call transcript will be posted shortly after this call. You can find call transcripts and other conference call information by selecting CMS Sponsored Calls on the left side of the ICD-10 Web page located at www.cms.hhs.gov/ICD10.

CMS will not be offering Continuing Education Units for this conference call. However, Sue Bowman will discuss the American Health Information Management Association CEUs later during her presentation.

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. Two practicing physicians will also be part of our discussion.

A PowerPoint has been developed and posted on the ICD-10 CMS Sponsored Calls Web page for participants to follow along with the presentation. Our first speaker today is Pat Brooks, who is Senior Technical Advisor at CMS.

Pat is going to provide information about ICD-9-CM, why a new coding system is needed and what characteristics are needed in it, reimbursement and quality problems with ICD-9-CM and benefits of adopting the new coding system.

Pat?

Pat Brooks: Thank you, Ann. If you will follow along with me, I'll start on slide 3 and discuss first the history of ICD-9-CM. The World Health Organization, or WHO, developed ICD-9 for use worldwide. After that, the U.S. decided to develop a clinical modification, which we referred to as ICD-9-CM, with the CM standing for clinical modification. This was implemented in 1979 in the United States, and it expanded the number of diagnosis codes from that developed by WHO. The U.S. also developed their own procedure coding system to go along with this code, ICD-9.

Slide 4 discusses the users of ICD-9-CM. ICD-9-CM diagnoses are used by all types of providers. The ICD-9-CM procedures are only used in an inpatient hospital. So when we discuss later the ICD-9-CM codes and the new procedure codes with ICD-10, it will not apply to those who are not inpatient facilities. The current procedural coding system, or CPT, is used for ambulatory and physician coding reporting.

Slide 5 covers what ICD-9-CM is used for. ICD-9-CM is used to calculate payments; specifically, the Medicare Severity DRGs are based on ICD-9-CM codes. The codes are also used to adjudicate coverage, and the diagnosis codes, once again, are used for coverage decisions in all settings. It's used to compile statistics and also to assess quality.

Slide 6 shows that ICD-9-CM is outdated. Obviously, it's 30 years old and much has changed in technology and medical practice in the last 30 years. Many categories of ICD-9-CM are full. And, also, it's not descriptive enough.

Slide 7 discusses why we need a new coding system. There's two main points that I'll mention and first is reimbursement. A new coding system would enhance accurate payment for services rendered. And, also, a new coding system would assist with quality to facilitate the evaluation of medical processes and outcomes.

Slide 8 discusses the characteristics needed in a new coding system, and there are two main characteristics that are needed. First of all, a coding system needs to be flexible enough to quickly incorporate emerging diagnoses and procedures. And it also needs to be exact enough to identify those diagnoses and procedures precisely. ICD-9-CM is neither of these. It's not flexible enough and it's not exact enough.

Slide 5 gives an example of a reimbursement and quality problem with ICD-9-CM. And it's specifically a procedure problem. In the example - I'm sorry; it's a diagnosis problem.

The example is for a fracture of the wrist. A patient comes in with a fracture of the left wrist. A month later, the same patient fractures their right wrist. ICD-9 does not identify left versus right. So you can't look at the codes and see that it was two separate injuries. It requires additional documentation.

ICD-10-CM describes left versus right, whether it's initial encounter or subsequent encounter, and also information on how it's healing or if there's nonunion involved.

Slide 10 provides an example of a procedure problem with ICD-9-CM. An example is for the procedure for the insertion of a combination defibrillator pacemaker device. With ICD-9-CM having so much - so many - chapters full, we were not able to assign a new code for this type of device with the other cardiovascular procedures in the cardiovascular chapters.

So this type of defibrillator code is assigned in the very front of the book, not in the appropriate chapter. We've discovered already that coders and researchers are having trouble finding codes when we put codes in erratic places, not in the places where they belong. ICD-10-PCS provides distinct codes for these types of devices in an orderly manner that's easy to find.

Slide 11 discusses the benefits of adopting a new procedure coding system. First, it would incorporate greater specificity and more clinical information, and this would result in improving our ability to measure healthcare services. It would increase sensitivity when we're refining groupings and reimbursement methodologies such as MS-DRGs. It would enhance the ability to conduct public health surveillance, and it would also decrease the need to include supporting documentation with claims.

Slide 5 points out that today's presentation is being covered by the four Cooperating Parties. And on slide 12, each will discuss their organization's perspective on ICD-10 and any implementation issues.

I will be covering, specifically, an overview of ICD-10-PCS and procedures and representing CMS; Donna Pickett from CDC will be discussing the ICD-10-CM diagnoses; Nelly Leon-Chisen from the American Hospital Association will be discussing the AHA's role and views on implementation of ICD-10; and Sue Bowman from the American Health Information Management Association, AHIMA, will discuss their role and views on

implementation. And then we will have some physician views on implementation.

Ann Palmer: Thanks, Pat. Donna Pickett, who is Medical Systems Administrator at the Centers for Disease Control and Prevention, is now going to discuss the history of ICD-10, the countries using ICD-10 and ICD-10-CM development, reviewers, major modifications, benefits of enhancements and structural differences.

Donna?

Donna Pickett: Thank you, Ann. ICD-10 was endorsed by the World Health Assembly in 1990 and includes diagnoses only. In 1994, WHO released the full set of ICD-10 books that includes the tabular lists, the alphabetic index, and instructional volume. As of 2002, ICD-10 had been published in 42 languages, including the 6 official WHO languages.

Implementation of ICD-10 has occurred in 138 countries for mortality and more than 99 countries for morbidity. The United States implemented ICD-10 in January 1999 for the reporting of death certificates and the conditions listed on those death certificates. Among the countries that are - have - already implemented ICD-10, many of those countries are using ICD-10 or a clinical modification for reimbursement or case mix.

In slide 15, you will see a list of those countries that began implementation as far back as 1995, coming toward the present to Canada in 2001. And, again, these countries are using it for either reimbursement or case mix. There have been many more countries that have migrated to ICD-10 or a clinical modification since 2001.

The countries that have been using ICD-10 or a clinical modification have also developed their own procedure coding systems and refined DRG or case mix based systems based on their own national clinical standards and practice.

Some countries not looking to reinvent the wheel, so to speak, have adapted or adopted case mix or reimbursement systems implemented already in other countries, and this would include Thailand and Ireland that have adopted the Australian modification of ICD-10.

The development of ICD-10-CM began in 1995 in conjunction with consultations with physician groups, clinical coders and other users of ICD-9-CM and included a thorough review of previous Coordination and Maintenance Committee recommendations that could not be incorporated into ICD-9-CM due to space limitations.

And, of course, ICD-10-CM is currently not in use at this time. Again, there were several phases of development beginning in 1995, and there was a public comment period between December 1997 and March 1998. Though ICD-10-CM is currently not in use, several countries have adopted or adapted modifications that have been made in ICD-10-CM. And WHO has also incorporated some of the changes that have been made in ICD-10-CM into the ICD-10 as published by the World Health Organization.

On slide 17, you'll see a partial list of reviewers who worked with CDC in the development of ICD-10-CM enhancements. And, again, the enhancements incorporated comments that were made by the public in 1997 through 1998. And you will hear additional information later in the presentation regarding field testing of ICD-10-CM. Slide 18 also provides a partial list of reviewers for your information.

In slide 19, there is a summary of the major modifications that have been made in ICD-10-CM. Those modifications include the addition of trimesters to the OB codes. The fifth digit codes that are in ICD-9-CM will not be used. It was felt by many of the groups that we worked with that the fifth digits in ICD-9-CM were not clinically useful.

The diabetes codes, the fifth digits that are currently in ICD-9-CM, will not be used in ICD-10-CM, and there is a new structure for the diabetes codes that is consistent with international consensus regarding the classification of diabetes. There are also expanded injury codes and added - we've added - extensions for injuries and external cause of injuries.

To give you an example of the expansions as it relates to the - some of the - injury codes in ICD-9-CM, open wound includes lacerations that are with or without mention of foreign body or traumatic amputation. Open wound also includes puncture wounds with or without foreign bodies and animal bites.

Complicated wounds in ICD-9-CM includes with mention of delayed healing, delayed treatment, foreign body or infection. In ICD-10-CM, each of those entities has been expanded out to being uniquely identified so that it'll be easier to identify the actual type of injury that the patient has and what is actually being treated. It was felt that this information and detail would be much more clinically meaningful than the way the codes are currently structured in ICD-9-CM.

In slide 20, you'll see an example of the laterality that has been added to ICD-10-CM. Code C50.1, Malignant neoplasm of central portion of breast, has extended characters at the sixth digit level to identify Malignant neoplasm of central portion of the right female breast and additional code to identify Malignant neoplasm of central portion of the left female breast.

The benefits of ICD-10-CM enhancements include the fact that ICD-10-CM has been harmonized with more current terminology and classifications. ICD-10-CM Chapter 5 has been harmonized with DSM-IV, the Diagnostic and Statistical Manual of Mental Disorders and also has been harmonized with ICD-0-2, the successor of ICD-0, which was the basis for ICD-9-CM.

ICD-10-CM also harmonizes with the - several - nursing classifications and the nursing diagnoses. And there is approximately a 90 to 95 percent harmonization with the nursing classifications.

Now, what are some of the structural differences between ICD-9-CM and ICD-10-CM? In slide 22, we provide information about the structure of ICD-9-CM codes, and that's the diagnoses codes. The ICD-9-CM codes are three to five digits, there are 17 chapters, and all characters are numeric in Chapters 1 through 17. There are also two supplemental chapters, and the first digit is alpha. And that's the E codes, the External Cause of Injury codes, and the V codes, which includes other types of encounters. Examples we provided here are Code 496 for Chronic obstruction, airway obstruction not elsewhere classified; a four digit code, 511.9, for Unspecified pleural effusion; and a V code, V02.61, for Hepatitis B carrier.

In contrast, ICD-10-CM, while it still has a very similar structure, is three to seven digits. The first digit is an alpha character, A through Z, and is not case sensitive. The second character is numeric. The third character is alpha or numeric and, again, for the alpha character, it is not case sensitive. Digits four through seven are alpha and, again, not case sensitive or numeric. And slide 23 contains examples of some of the codes that are found in ICD-10-CM.

Full code titles are also included in ICD-10-CM. By way of example, in slide 24 - as you can see, ICD-9-CM, the Code Title 143 - the Category Title - I

should say, 143 is Malignant neoplasm of the gum. At the fourth character level, you have 143.0, Upper gum, and 143.1, Lower gum. In order to create a full title that would be meaningful to a human reader, you would need to add the terms at the category level to the terms at the subcategory level to have a complete code title. In ICD-10-CM, the code titles are complete as printed in the classification.

For more information about ICD-10, you may visit the CDC Web page where you will find information about the ICD-10 as used by mortality statistics and also the files for ICD-10-CM, general equivalence mappings, and other information related to ICD-10-CM.

CDC will, at the end of the year, be posting the 2009 version of ICD-10-CM which will include a tabular list, the alphabetic index, updates to the general equivalence mappings, and the ICD-10-CM coding guidelines.

Ann Palmer: Thanks, Donna. Now, Pat Brooks is going to discuss the development of ICD-10-PCS, structural differences of ICD-9-CM and ICD-10-PCS, advantages of ICD-10-PCS, and impact on Medicare Severity Diagnosis Related Groups.

Pat?

Pat Brooks: Thank you, Ann. I'd like to stress one more time that ICD-10-PCS is being developed as a replacement for the ICD-9-CM procedures, and it's only intended to be used on inpatient hospital settings. So those of you who do not work in those settings, at least you'll hear what it's about today, but you would not be using this new coding system if you do not work in the inpatient setting.

The ICD-10-PCS, the PCS stands for procedure coding system. And as slide 27 shows, we developed our first full version of ICD-10-PCS in 1998. And

since that time, we've discussed it in our public Coordination and Maintenance Committee meetings, and we've solicited inputs from a number of reviewers and the public. And we've made annual updates since that time, and the system is not in use at this point.

Slide 28 just gives you an overview of what ICD-9-CM looks like. It's three to four digits long and obviously with the codes structured this short, you can understand why it becomes difficult to update it and why it may not be as detailed and specific.

I'll show on slide 28 two examples of the ICD-9-CM procedure codes. One is one with only three digits, the 43.5, and the other is an example of a four digit code for the suture of duodenal ulcer site.

Moving on to slide 29, we illustrate ICD-10-PCS and its structure. ICD-10-PCS has seven digits. It's always seven. They can be either alpha or numeric, and when there's an alpha character, it is not case sensitive. We have used only numbers - we've used numbers 0 through 9 - but we have not used letters O and I, so that we avoid confusion with the numbers 0 and 1. And at the bottom of page 29, we have two examples of alphanumeric ICD-10-PCS codes. And you can clearly see how that you're able to incorporate information about the approaches used and much more information with this detailed type of a coding system.

Example 30 shows a very common ICD-9 procedure code for angioplasty. This particular code - when it's used - you really can't tell exactly what's done, and frequently in a hospital setting, you'll have to report multiple codes to show if stents were inserted or if multiple vessels were done or what the approach might have been. With ICD-10-PCS, that will map into 1,170 ICD-10-PCS codes. And while that may sound like a lot of codes, coders in a

hospital setting will now only have to report one code frequently to identify what was done as opposed to maybe up to three or four codes using ICD-9-CM to get equal amount of information.

These codes tell the exact body part, in other words, the vessel that the angioplasty's performed on, the approach - was it open, closed, endoscopic - and if a device is used and, specifically, what kind of device. And, once again, those in the inpatient setting are aware that one specific ICD-10-PCS code carries much more information.

Turning to slide 31, we'll discuss the advantages of ICD-10-PCS. One important advantage is it'll probably provide greater detail of procedures since we have more room and the codes are - have - five digits, we're able to provide more information into one code. There's also ample space for capturing new technology and new devices. And there have been a number of advances in this area since ICD-9 became implemented in 1979. The other benefit is ICD-10-PCS is a very logical structure with clear, consistent definitions. So, in many ways, it's much easier to teach than it is to teach coders how to use ICD-9-CM in the hospital setting.

Slide 32 shows that we have complete information on ICD-10-PCS posted on our web page. Currently, you have the 2008 version, and we do update that each year. And when you look at that page, you can find the complete Tabular Section of ICD-10-PCS and also the Index Section. And it is interactive; you can type in and go to the various pages and learn how to use this system.

As with CDC, we will be updating all our files and posting the 2009 version of ICD-10-PCS by the end of December 2008. We have a User Guide Manual that includes the official coding guidelines on our web page. So those of you

who work in inpatient settings can go there and begin to understand how PCS works and how to use it.

We also have some mapping files that map between an ICD-9 procedure code and ICD-10-PCS, and those are forward and backward mapping. We refer to these as general equivalency mappings. And when you go to look at these files, we also have guidelines and instructions on how to use these mappings to make it simple.

And I'll mention to you also, based on requests we've received from the public, we will also be putting a reimbursement mapping up at the end of this year with the one best code as far as reimbursement - just in case there are insurers or quality people who want to make a quick conversion. And that'll be another tool that will be available at the end of this year.

We have PowerPoint speaker slides for those of you who want to educate others in your facility about what ICD-10-PCS is all about, and we also have a technical paper explaining the system. And I've included for you our website where you can find out all this information.

Slide 33 discusses something that we did. People have questioned us how well the maps work – maps between ICD-9 and ICD-10. And we've performed an exercise in using those maps to convert the payment system used in the inpatient setting, the MS-DRGs. We began a process of converting MS-DRGs from ICD-9-CM to ICD-10-CM and ICD-10-PCS. We selected the digestive system just as a place to begin, and we used those mappings that are present now to see how well we can convert that payment system.

We presented the results of this exercise at the September 24 thru 25 ICD-9 Coordination and Maintenance Committee Meeting. And slide 66 shows a

place where you can find out more information about the summary report for this meeting and the specific slides that discuss this exercise and using the maps. But let me just say that we were very pleasantly surprised - we found over 95 percent of the MS-DRGs for the digestive system could be converted automatically using these maps.

Sometimes, though, we had to stop and do a little bit of clinical analysis if there are several codes involved with the maps to see which one was best. But overall, we were very pleased with the progress and we think that as we learn and proceed with the rest of the MS-DRGs, that conversion process will go even better.

We are converting the rest of the MS-DRGs to ICD-10 and we will have that done by October 1, 2009. And at each future meeting of the Coordination and Maintenance Committee, we will be discussing our progress so you could follow the exercise there.

We would encourage anyone who wants to learn how to convert their own internal data or to convert whatever systems they have to follow this and learn how to use these mappings for their own application.

I'll have to mention also that while this exercise is to show that the mappings work and to learn from it, any final version of the MS-DRGs that's based on ICD-10 codes would be subject to formal rulemaking.

Over time, as we get data used under the MS-DRGs - used in ICD-10 - we would hope to take advantage of the increased detail in the codes to make additional refinements to MS-DRGs to take advantage of all this. And, once again, all of this information will be posted by the end of December 2008 in our updates of the ICD-10-PCS.

Ann Palmer: Thanks, Pat. Nelly-Leon-Chisen, who is the Director, Coding and Classification at the American Hospital Association, is now going to discuss AHA's role, plans, and implementation issues regarding ICD-10.

Nelly Leon-Chisen: Thank you, Ann. As has already been mentioned, the American Hospital Association has been involved with ICD-9-CM for quite a number of years, and AHA is one of the Cooperating Parties.

So, today I'll talk about the Central Office on ICD-9-CM, our role in providing coding education today through our publications, our audioseminar series and speaker's bureau, and then share information with you regarding our thoughts and plans for ICD-10-CM and ICD-10-PCS education and implementation.

On slide 36, we have some information about the AHA Central Office on ICD-9-CM. This office was created 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 direct responses are provided free of charge. The questions can range from simple questions related to locating a fifth digit to more complex questions for new conditions or new technologies where the classification does not readily provide guidance.

The goal 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.

Moving on to slide 37 - 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 develop educational materials and programs on ICD-9-CM, including audioseminars on hot topics, but our best known resource is the AHA Coding Clinic for ICD-9-CM.

Moving on to slide 38, Coding Clinic has been in continuous publication since 1984. It is a quarterly newsletter devoted strictly to ICD-9-CM coding. It consists of an Ask the Editor section, which has the frequently asked questions received by our office or questions that have never been addressed and that therefore need wider dissemination.

These are real world questions received through our clearinghouse service, and I'm sure that many of our listeners on today's call have sent us their questions in the past and have seen answers addressing their specific questions published in Coding Clinic. Periodically, we also publish more extensive educational articles in the coding of more difficult scenarios. Some recent examples have been respiratory failure and sepsis.

And then our fourth quarter issue is typically the largest issue of the year. And this contains the ICD-9-CM code updates that come in every October with additional clinical information to help educate our coders on the new codes as well as examples on how to apply these new codes.

Starting with the third quarter issue of this year, we have introduced a new section under reporting of Present on Admission or POA indicators as we work with CMS to develop a process for handling those questions through our existing ICD-9-CM process.

The Coding Clinic publication is supported by the Cooperating Parties and the Editorial Advisory Board so that the content of every issue is approved by these groups before we can publish. The EAB includes representations from physician groups like the American Medical Association, the American Academy of Pediatrics, the American College of Surgeons, and the American College of Physicians. We also have coding representatives who are currently employed by providers.

Starting on slide 39, we list the major functions of Coding Clinic. These include providing official ICD-9-CM coding advice because you can rely that every question and answer has been thoroughly discussed and approved by the Cooperating Parties and the EAB. And we also republish the official guidelines and any changes to those guidelines.

We answer questions on code assignments and also address issues of sequencing of codes which may impact on the information that is submitted, especially if we're looking at the selection of principal diagnosis.

We serve as the current reference on regulatory and other requirements for reporting diagnostic and procedural information for medical records. And over time you have seen issues describing what documentation may be used for coding. Like, for example, documentation from different types of providers. We also present topics and articles that provide practical information. These topics are generated from the requests for coding advice that we receive. The goal, again, is to improve the technical coding skills of ICD-9-CM users. And

as such, we address issues facing ICD-9-CM users on data reporting requirements or problems with data edits.

So, for example, we deal with situations where there may be problems with a combination of codes, whether it's possible to use two codes together or not, record documentation, and other ICD-9-CM related matters.

On slide 41, let's talk about the Faye Brown ICD-9-CM Coding Handbook. We believe that the AHA's ICD-9-CM Coding Handbook may be the first ICD-9 coding training book that was published in the United States back in 1979. It was developed by Mary Converse, the founder of the AHA Central Office. It's the textbook used in many coding and HIM programs around the country, and it's now annually revised by the AHA Central Office staff.

On slide 42, we talk about what we have done so far in ICD-10, and what we envision our roles to be in the future. Because we believe ICD-10 to be extremely important to our members and their future, we have been actively involved in ICD-10 over the last 20 years and intend to continue to do so into the future.

We have participated in the development of ICD-10-CM and ICD-10-PCS through the Technical Advisory Groups and provided extensive review over the years. AHA members as well as the AHA Central Office on ICD-9 staff participated in real world testing of both ICD-10-CM as well as ICD-10-PCS. You'll hear more details on the joint AHA/AHIMA-led ICD-10-CM field testing from Sue Bowman in a few minutes.

I'd like to add to that - that - as part of the ICD-10-PCS informal testing, we submitted two years of surgical questions referred to the AHA Central Office for coding advice. These questions required further referral to the Coding

Clinic Editorial Advisory Board because distinct or clear ICD-9 procedures codes could not be found.

Where the EAB had been required to spend a significant amount of time deliberating over the correct ICD-9-CM code selection, the field testing found coders were able to easily and accurately assign an ICD-10-PCS code without any problem. We found the testing overall to have been thorough and representative of the types of medical records that would be coded under ICD-10-CM and 10-PCS.

Over the years, we had published articles on ICD-10 and done multiple presentations on the subject. You will find a few of them on our website. As part of our long time preparations for ICD-10, since 2004 the Faye Brown Coding Handbook has contained preview chapters on ICD-10-CM and 10-PCS.

These chapters provide an overview not only of the code structure and how the coding systems compare to what we're familiar with in ICD-9-CM, but also information and checklists on how to start preparing for ICD-10 implementation – whether this would be for an individual such as an HIM professional or a coding professional or for an institution – in terms of what kinds of things should be considered, personnel training, systems issues or data conversion.

So our future plans for ICD-10, looking at slide 44, include a Central Office on ICD-10, Coding Clinic for ICD-10, Train the Trainer programs, as well as education and outreach for hospitals and others.
We think that the AHA Central Office on ICD-10 would continue to support coding questions through a clearinghouse function, 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 Coding Clinic with the collaboration of the Cooperating Parties.

On slide 46, we envision that the major functions for Coding Clinic for ICD-10 would continue to be similar to what we currently have for the AHA Coding Clinic for ICD-9-CM and it would also continue in the same format, namely, a hard copy subscription or electronic CD or available through encoder products where many of them, if not all of them, already contain Coding Clinic.

Moving on to slide 47 - educational plans - we have already started our educational outreach as far as ICD-10 and you can see that this has been several years in the making. And more recently, we have developed a member advisory that went out to all our hospitals and it's also available through our website.

As far as Train the Trainer programs, we believe that there are going to be many different levels of training required. We're ready to help health information management professionals as they try to explain and talk through the implementation process, whether it is with senior management at their own institutions or working with other departments to try to identify what are the areas that are impacted and how this should go step-by-step working with other departments that would be affected.

We would work with State hospital associations to try to reach as many hospitals as possible. The training and education, again, would depend on the role that each individual would play within the facility. Some folks would only need an overview versus in-depth training for coding professionals - depending on the individual role - and the timing, of course, would also change. In-depth training of coding professionals would be three to six months

prior to implementation, but general overviews for folks that are looking at their information systems, trying to determine the impact and trying to budget for it, would be receiving more general overviews earlier in the process.

I would like to emphasize that there needs to be an assessment of what is needed. And individuals would need to consider where and how they would purchase their educational resources. We realize, like with so many other new initiatives that providers have had to deal with, that there will be many, many offerings. So we would want to make sure that these offerings come from sources that hospitals and other coding professionals have learned to trust over the years.

On slide 48, we have a summary of the major implementation issues that hospitals should look at for this major initiative. Obviously, budgeting is something that needs to be considered, and it's something that would need to be done over several years because this is a multi-year implementation process that involves different areas.

The areas affected would be personnel training and, again, that would depend on the role of the individuals. Also you would need to work with medical staff to ensure appropriate documentation is available, not to say that you would need to retrain physicians in order to assign ICD-10-CM or ICD-10-PCS, because we have seen through the pilot testing that it is possible to assign codes based on today's documentation.

But if we’re going to reap the benefits of greater specificity, we need to make sure our medical staff understands what the benefits are of greater specificity so that we can reduce the number of physician queries required in order for us to assign the right codes.

And as we know, coded data is used in many, many other areas in today's environment. And so, the greater specificity that can be provided to administrative data sets, the better off we're all going to be whether we're looking at information for quality reporting, patient safety or simply just trying to see what actually happened to individual patients.

There obviously would need to be a lot of hardware and software changes, and again, that will vary from institution to institution depending on what systems you have, whether they are from the same vendor, whether the different applications communicate with each other, and whether you have systems that are home grown or commercially available.

And then data conversion - not every system would need to be converted and so it would be on a case-by-case basis. Decisions would need to be made as to whether you want to convert everything that you have, or only as needed, or as required for specific types of analysis. Again, this is not going to be a one-size-fits-all implementation process.

But for now what you need to do is - and we're moving on to slide 49 now - is to start looking at how you're going to tackle this big initiative. Obviously, because this crosses over into multiple departments, you're going to need a cross-functional team. This would involve collaboration among the different departments in order to identify which systems are affected. The team would include members across clinical areas, financial areas and information system areas.

You may be surprised to find that, for example, certain physician clinics may have their own databases for a particular study that they're working on. There may be diagnosis codes that are manually entered directly into a database or

they may be transferred directly from another application. So it's important that everybody is aware of what this change means.

But most of all, there needs to be support or sponsorship from administration to make sure that everyone understands what the implications are and that timelines are developed. There will need to be support for trying to get the budget through and understand where things need to be prioritized. And obviously the HIM department leaders as well as the coders would need to be involved as well.

Moving on to slide 50, some initial activities at this point would be to conduct systems inventory. And this is the only way you're going to be able to determine where those databases exist that use ICD-9-CM. You'll need to determine what software programs do you have, where they reside, whether you need to work with your commercial vendors to determine when they would be ready and what their plans are for implementation.

On the other hand, if you have a homegrown or proprietary program unique to your individual facility, you'll need to determine whether you still have the resources available internally to make changes to those systems, or whether you'll need external help to migrate to make those changes, or even consider migration to something a little more generic that may be able to be integrated with something that you already have from a commercial vendor. So you can see there's going to be a lot of variability from facility to facility.

But no matter what you do, as you plan for future expansions in your information systems, you need to be sure that your vendors are aware of this change to ICD-10 so that you're not surprised later and these systems are not able to accommodate the new system.

Moving on to slide 51, as far as timing is concerned, we have been recommending that our members start preparations way before now; actually, before our final rule, before an implementation date is set. Don’t wait for the final rule because you're wasting precious time.

So in order to even identify how long it will take for the implementation or what you will need to do, you need to get started right away if you haven't already done so. We have found that many hospitals have already done a basic gap analysis some time ago when we thought that the NPRM was going to come out earlier.

But in any case, those plans and those inventories would need to be revisited because things may have changed in your facilities since that time. And once you realize and you decide where things need to change, then that’s when you'll be able to get a better idea of what the estimated timeframe for making changes or for making any software upgrades will be, because you can depend on it - that it will take time. It will take time not only to make those changes, but to coordinate this effort across different areas within the hospital.

So, again, if you haven't already done so, get your cross-functional team started. Start thinking about who you need to invite. And, again, remember we do have time; you don’t have to rush and buy full-blown ICD-10-CM,/PCS training at this point.

There will be time to train the coding professionals. At this time, basically you're trying to create the infrastructure you plan in terms of how you're going to proceed.

On slide 52, you have a number of links directly to the Central Office on ICD-9 and a section on ICD-10 where we'll be posting materials and information as we move forward and help you along with the implementation process.

((Crosstalk))

Ann Palmer: Thank you, Nelly.

Nelly Leon-Chisen: Thank you.

((Crosstalk))

Ann Palmer: At this time, Sue Bowman, who is Director of Coding Policy and Compliance at the American Health Information Management Association, is going to discuss AHIMA's role regarding ICD-10 including academic and educational plans...

((Crosstalk))

Sue Bowman: Thank you, Ann. First of all, for those of you who hold an AHIMA credential, you may report two Continuing Education Units, CEUs, for today's conference call. Simply report the two CEUs as part of your regular reporting cycle and keep a copy of today's handout, the slide presentation, in case your CEUs are ever audited by AHIMA.

It would also be beneficial for your organization to maintain some type of internal attendance record - also for auditing purposes to show that you and anyone else in your organization who was claiming AHIMA CEUs attended today's program. If you hold credentials from an organization other than

AHIMA, you would need to contact that organization regarding their CEU requirements.

Now, as Ann mentioned, I'm going to talk a little bit about what AHIMA is doing as far as preparing our academic programs, developing our education training and resources, and also about the testing that was done and AHIMA's recommendations for implementation, planning and preparation.

Since coding is a core function of the health information management profession and improving data quality is a key part of our mission, AHIMA is committed to working with the healthcare industry to ensure a successful transition to ICD-10-CM and ICD-10-PCS.

AHIMA has a long history of providing coding education and resources to coders and other health information management professionals working in a variety of healthcare settings.

And in fact, we've been involved with ICD-10-CM and 10-PCS preparation and planning including providing input to the development of the systems themselves, participating in testing of these coding systems, and developing resources for a number of years now.

In addition to providing education to experienced coding and other health information management professionals, AHIMA developed curricula for associate, baccalaureate and master's in heath information management programs. These curricula are obviously one of the first areas that will need to be updated to reflect the ICD-10-CM and ICD-10-PCS.

The HIM curriculum at all academic levels currently already have ICD-10 as a required knowledge cluster, but as implementation plan moves forward and

we get closer to an actual implementation date, the content of our educational programs will continue to expand to include more ICD-10.

Obviously, we can't just turn the switch and go from ICD-9 to ICD-10 in our educational programs because graduates will still need to understand and have knowledge of the ICD-9 coding system for some time now. But as we move closer, they will gain more and more knowledge and education in the ICD-10 coding systems.

Our Education Strategy Committee is developing a transition and implementation strategy to pull ICD-10 coding reimbursement and change management knowledge clusters into both our associates and baccalaureate curricula. The master's level programs will also be updated to reflect changes in managerial and organizational skills because of the adoption of new coding systems.

The approval committee for certificate programs at AHIMA will develop an impact plan for approved coding programs, including comprehensive training on ICD-10 in our model coding curriculum.

Our AHIMA Virtual Lab, which is a system we have through the Web that allows virtual access to a full array of health information management technologies, will incorporate the ICD-10 as well.

We will use our educational relationships through our international educational work group of educators to take advantage of those colleagues in other countries who have already had the experience of converting to ICD-10 and can assist us with conversion strategies.

We also have a new product available to our educational programs called "CourseShare" that allows people to share programs and educational materials that they've already developed in order to not reinvent the wheel at each program and have HIM educators benefit from what other people have already developed. And it allows the Web to be a great conduit to quickly distribute ICD-10 information to all of our HIM educational programs so that they have up-to-date, first-rate information.

Regarding our educational plan for current practitioners in the field and the healthcare industry, we are developing a targeted educational model for defined ICD-10 audience segments including different categories such as HIM and executive level leadership, educators and current students, as I already mentioned, experienced coders, managers of data who will need to have some level of knowledge of ICD-10 as well as care providers that also need to have some level of knowledge but a different kind of knowledge than perhaps the people actually doing the coding.

This educational model will be tailored to address varying needs over time leading up to the implementation date - excuse me - recognizing that there will be different levels of training needs, including general, expert and maintenance level training.

On slide 59, we showed some of the resources we currently already have available. We have two ICD-10 online courses, 10-CM overview and a 10-PCS overview, that gives you a flavor of the different coding systems. We have an ICD-10 Preview Book, an ICD-10-CM Proficiency Assessment that allows you to test your current knowledge of ICD-10-CM. We will - excuse me - we will soon have an ICD-10-PCS Proficiency Assessment. We have an ICD-10 implementation preparation checklist on our website.

We've given a number of audioseminars over the years, and spoken at a number of conferences. And have had a number of articles published in our journals. We have an ICD-10 page on our website that provides quite a bit of additional information related to ICD-10.

We also provided Webinars immediately after the NPRM came out, and the resource materials for our free Webinar is also available through the ICD-10 page on our website.

Some of the transition resources that we are working on developing - our implementation guidance for the different categories that we've identified including the healthcare organization that has to plan for moving forward to ICD-10, our certified coders and the need for them to maintain their credentials and demonstrate a level of ICD-10 knowledge in order to ensure that credential represents some - that - level of knowledge. I already mentioned the shift in curriculum in the educational institutions.

We will also be developing some practical change management tools to assist organizations with implementation planning and preparation, including things such as toolkits and checklists, talking points to use in the organizations. And some information about lessons learned from other countries and organizations that have been through this before - we can learn from some of their experiences and what worked and what didn’t work.

Now I'm going to talk a little bit about the ICD-10-CM and ICD-10-PCS testing that has been done. For ICD-10-CM, there was actually a formal testing project that was done by AHA and AHIMA in a collaborative arrangement that Nelly had referred to earlier. The purpose of this testing project was to assess the functionality and utility of applying ICD-10-CM

codes to actual medical records in a variety of healthcare settings and to asses the level of coder education and training required.

Six thousand one hundred and seventy-seven medical records were coded by credentialed health information management professionals in a variety of healthcare settings. And while these were credentialed coding professionals, none of the individuals who participated in the study had ever had any previous ICD-10 coding experience.

The participants received only two hours of non-interactive training and yet, the coding accuracy and the understanding of how to use the coding system were surprisingly good as determined by a combination of validation of the sample of the assigned codes as well as reviewing the types of questions and comments submitted by the participants.

The result of this project showed that ICD-10-CM was felt to be definitely a significant improvement over ICD-9-CM, and the ICD-10-CM was much more applicable to non-hospital settings than ICD-9-CM. The clinical descriptions in ICD-10-CM were thought to be much better than in ICD-9-CM. And the notes, instructions and guidelines in ICD-10-CM were thought to be clear and comprehensive.

Interestingly, only 12.3 percent of the recorded ICD-10-CM codes in the project fell into the unspecified category, meaning that the word “unspecified” or “not otherwise specified” was in the code title. The small percentage of reported codes that were nonspecific in nature indicates that the medical record documentation necessary to support the coding specificity appeared to be present in the majority of the medical records that were coded and these were actual medical records in people’s own facilities.

So we concluded from this that ICD-10-CM codes can be applied to today's medical records in a variety of healthcare settings without having to change documentation practices significantly, although improved documentation would certainly result in higher coding specificity and, therefore, higher data quality in some cases. We asked the participants for input on a series of questions following the conclusion of the project, and they felt that ICD-10-CM wasn't nearly as hard as they thought it would be when they went into the project.

As Nelly mentioned earlier, the conclusions of this project showed that intensive coder training should occur three to six months prior to implementation. Participants felt that intensive training too early would be a waste of time because if people weren't actually assigning ICD-10 codes, they would have to be retrained as implementation approached.

A survey of the participants indicated that two to three days of training for ICD-10-CM was felt to probably be adequate, which is consistent with AHIMA's current estimate.

For ICD-10-PCS testing, formal testing was conducted by CMS contractors who coded 5,000 records and an additional comparison tests of 100 records. Participants in the formal testing received two days of training on the Med-Surg section of ICD-10-PCS and one day of training on the other sections.

Informal testing was also conducted by AHA and AHIMA volunteers. The results of this testing showed that after an initial learning curve, participants were able to use ICD-10-PCS pretty easily.

While ICD-10-PCS requires a greater understanding of anatomy in some areas, the body part key being developed to accompany ICD-10-PCS should

help with this because the body part key translates anatomical sites likely to be documented in the medical record, such as specific bone to body part terms used in ICD-10-PCS. So, for example, you can easily determine if a particular bone should be classified to the hand versus the wrist.

ICD-10-PCS was felt to be much more complete than ICD-9-CM with greater specificity. Precision of ICD-10-PCS resulted in greater detail about the nature of the procedure. It was very easy to expand the system, and the multi-axial structure made it easier to analyze. Also, standardized terminology makes it easier to use once the coder has initial training. And having all of the terms defined in ICD-10-PCS makes it easier to teach. So that kind of covers, in a nutshell, the testing.

On slide 62, I'll cover a little bit about our implementation planning recommendations. First of all, the first stage of preparation involves assessing the impact of the change and identifying key tasks and objectives.

An interdisciplinary steering committee to oversee ICD-10 implementation should be established. The steering committee should develop the organization’s ICD-10 implementation strategy and identify the actions, persons responsible and deadlines for the various tests required to complete the transition.

The implementation plan should include estimated budget needs for each year leading up to implementation, as well as any post-implementation budgetary issues, such as additional training needs or the needs for contractors to assist with coding backlogs or resolution of identified post-implementation problems.

An internal timeline should be developed including identification of the resources that will be needed. The planning phase represents a great opportunity to reassess and refine operations. ICD-10 awareness training should be provided to affected departments and medical staff so that they are aware of the coming transition and what it means for them and can start evaluating the impact on their areas of responsibility and any budgetary implications.

Staff education needs to be assessed. Who needs education and what type and level of education do they need? What method of education would work best for different categories of individuals in terms of effectiveness of training and cost?

It's definitely not too early to start looking at the medical record documentation and identify areas that would benefit from improvement. This represents an opportunity to evaluate the quality of the documentation for a variety of purposes and implement documentation improvement strategy if necessary.

And you might actually be surprised at how much of the documentation that support ICD-10 is already there. There is a widespread assumption that the increased specificity in the ICD-10 code sets means that significant changes in documentation will be necessary.

However, you may find that much of the documentation is already present. For example, ICD-10-CM uses up-to-date terminology, whereas ICD-9-CM terminology is outdated. The documented clinical terms may more closely align with ICD-10-CM than with ICD-9-CM.

So, on slide 63, for the first steps for getting started with implementation is to look at acquiring resources to implement the plan, evaluate what the total financial impact will be to the organization and start planning the strategy including developing objectives, planning measurement tools, evaluation of strategies and then action steps towards implementation to assure a smooth and successful implementation.

The extent of changes to systems, processes and policies and procedures will need to be assessed. The changes that will need to be made to the various systems and applications that used ICD-9-CM codes or coded data will need to be assessed. A comprehensive systems audit for ICD-10 compatibility needs to be performed. This includes performing an inventory of all databases and systems applications that use ICD-9-CM codes giving consideration to how ICD-9-CM codes are used in each system. Where the codes come from? Are they manually entered versus imported from another system? How the quality of data is checked, and the interfaces between the systems.

Software changes including field size expansion, alphanumeric code composition, redefinition of code values and their interpretations and edit and logic changes also needs to be identified, as well as new or upgraded hardware or software requirements. And, of course, the budgetary implications of all of this would need to be determined.

Examples of systems and applications that need to be taken into consideration of having some impact from the change to a new coding system are shown on slide 64. But this certainly isn't an all-exhaustive list. All of the reports and forms that include ICD-9-CM codes will need to be identified because they will need to be modified to accommodate the ICD-10-CM and/or ICD-10-PCS codes, depending on the setting where these forms are being developed and used.

For example, superbills used by physician practices will need to be modified to reflect ICD-10-CM codes. And a sample of a portion of a physician's superbill that has been converted to ICD-10-CM is shown on slide 65.

Also, much of the information that I've just presented about what to think about in developing an implementation plan can be found in the implementation checklist that AHIMA developed, which is on our ICD-10 page on our website. And now, I will turn it back to Ann.

Ann Palmer: Thank you, Sue. Dr. Jeffrey Linzer, who is Associate Professor of Pediatrics and Emergency Medicine at Emory University School of Medicine in Atlanta and the Associate Medical Director of Compliance Emergency Pediatric Group Children's Healthcare of Atlanta, is going to discuss ICD-10 implementation issues.

Jeffrey Linzer: Well, thank you very much and good afternoon everyone. I think the biggest concern I've been hearing from physicians is - how much more work is this going to cause me? And the reality is, for physicians, as far as your documentation goes - none - absolutely none right now.

As a physician, if you write on - as your diagnosis - right separate of otitis media. Currently, that is just coded to acute separate of otitis media without the right or the left. Under ICD-10, that will now be able to be coded specifically to the affected ear.

And the other advantage in ICD-10 over ICD-9 is that if you were to see that patient again for a subsequent infection in the same ear, as you would write, return infection or subsequent infection in your medical record - that now will be able to be electronically captured. So, if you need to make a referral to that

patient for an otolaryngologist to evaluate, for example, that information is easily gathered electronically.

If you were to write that the patient had congestive heart failure, if you were to write that the patient had a fracture of the femur - none of that will be changed. None of that will be required for you to make any single difference. What happens is, is how that information now is translated into the EMR and how it's translated into the billing record.

So it really is the coder who's going to take the information and be able to take what you have written and put it into more detail. And make that information more easily gatherable and available to you. So that’s the first thing.

I wanted to reassure all the physicians - is - there really is nothing extra that you have to do. Probably the biggest work that you as physicians would have to be concerned about is expanding your superbill. And if you have diagnosis codes now on your superbill that you would check off - basically for things, again, for example, the ear infection - you could add a sidedness for right or left, acute or chronic.

So it really is not going to be that much more additional work for you as a physician. And I've been able to look at this in systems across the country and in other parts of the world. It really is going to be a straightforward transition.

The biggest problem I see as far as physician diagnostic terminology is something that we need to be working at in medical school - because right now physicians are not writing down terminology that is helpful to the coders who are helping us do our work. And that’s why the coders are coming back to you now asking you to clarify what you have written as a diagnosis because they need to be able to pick it out of the ICD-9 book. That’s not going to

change with 10. It's just going to make it easier for them to take the specific information that you're already writing in the medical record and being able to apply a code to that.

And that’s my basic message is of reassurance - that it really is not going to get in our way in taking care of our patients.

Ann Palmer: Okay. Thank you, Dr. Linzer. Now, Dr. Lee Hilborne, who is the President of the American Society for Clinical Pathology, Professor of Pathology and Laboratory Medicine at the University of California, Los Angeles, Health Services Researcher and Consultant to the RAND Corporation in Santa Monica, California, and the Medical Director of Quest Diagnostics in Southern California, is going to discuss ICD-10 implementation issues also.

Lee Hilborne: All right. Well, thanks, Ann. And it's certainly a pleasure to join everybody and the distinguished group of speakers on this call. I, too, like Dr. Linzer, am looking forward really to transition to ICD-10. Much of the issues have been laid out by Sue and Pat and Nelly and others about why it's so important for us to do that.

Based on the introduction, I think the point being is that I have sort of experience working in a number of different arenas. I certainly work in the clinical arena through my work at RAND. I do health services, health policy research, and have also been and continue to be a part of the team at UCLA working with HIM on coding utilization and so on - so I have a hospital administration piece.

And having been in that arena for a number of years, it’s - I remember at least over a decade ago talking about the transition to ICD-10 and how important that’s going to be. And when we think about the value of coding that, you

know, I've sort of a long time realized that the value of coding really applies in multiple dimensions and some of those were discussed today. Obviously, the issue started out for public health, and then reimbursement, and now really for quality assessment and improvement.

So in terms of public health reporting, we've already made part of the transition to ICD-10 in terms of mortality reporting and really so this is a matter of sort of going in all the way.

I think, as we've discussed, that ICD-9 simply doesn't have the capacity or the depth to meet the kinds of needs of all the stakeholders. And so we have to change. And while we manage to delay it for some point, we've really run out of time to do that. And I think the encouraging thing is that other developed countries, ones that we respect, have done it. Does that mean it's not going to be a challenge? Of course not.

And I know that there's been an ambitious timeline that's been suggested. You know, I don't know about the timeline, but I think that's something that we have to - that still needs to be discussed. And I know comments are coming in on it but irrespective of the timeline, that's not a really good reason for us not to get on the pathway to move where others have gone.

And I think to be successful in this, to realize the importance of public health for reimbursement, quality assessment improvement - it really requires that partnership between the payers, the government, the providers, with a particular strength for HIM professionals, and those of us who are clinicians to work together.

And as Dr. Linzer said, that you know, none of us who are clinicians were ever taught what to write in a medical record in medical school. And so I

don’t think that that issue changes but I think as - in fact that - transparency and accountability become much bigger issues that it will be important for, frankly, all of us to learn better to make sure that we know what we’re saying can be correctly interpreted by our HIM professional colleagues. And that will reduce the number of queries that we get but also will improve the use of the information for the purposes for which coded data are used.

So I personally am looking forward to making the transition. I don’t think it's gonna be easy or seamless. Nothing ever is but I think that - I think we’re ready to do it, and I think we need to get on the pathway.

Ann.

Ann Palmer: Well, thank you Dr. Hilborne. I'd also like to point out on the PowerPoint presentation that on slides 66 through 69, you can find Web resources and information that are available from CMS, CDC, AHA and AHIMA.

And at this time, we will answer participants’ questions regarding the topics presented today. Please note that the questions about the ICD-10 Notice of Proposed Rulemaking and specific coding questions are outside the scope of this call. Ken, could you please open up the phone lines?

Operator: Absolutely.

Ann Palmer: Thank you.

Operator: At this time, I would like to remind everyone if you like to ask a question, please press star then 1 on your telephone keypad. And I'll pause for just a moment to compile the Q&A roster. Again, that is star then 1 if you have a

question or a comment. And your first question comes from Rosalie Brown. Your line's open...

((Crosstalk))

Rosalie Brown: Yes. This has nothing at all to do with CPT coding at this time? We would still code visits and procedures the same way?

Pat Brooks: Yes. This is Pat Brooks and you are correct. This does not affect CPT at all. The only procedure volume that'll change will be for hospital inpatients that currently use ICD-9 procedures. They will begin to use ICD-10 procedure coding systems. So CPT, alphanumeric HCPCS, that stays the same.

Rosalie Brown: Okay, one more question. On November 17, there's another conference call and it says: "For Physicians." Now, is that for the doctors themselves that work with the patients to be on that conference call? Is it the same as this one?

Pat Brooks: This is Pat Brooks. It will be the exact same call, but we will be marketing it to physicians' offices and, frankly, to anybody that couldn't sign up for an earlier one. So if you heard it this time, you'll be hearing similar things on the repeat call for the physician's office.

Rosalie Brown: Okay. So, that's great and thank you.

Ann Palmer: Thank you.

Operator: Your next question comes from Deborah MacLachlan. Your line's open.

Deborah MacLachlan: Hello everyone. I wanted to say, first of all, thank you so much for the presentation today. This was a nice beginning for me. I didn't feel

overwhelmed at all. Most of you really did reassure me and give me a great start with where I need to look at things for my facility.

One question I do have has to do, actually, on the side of the billing sector of this. And I'm just wondering if anyone has been out there talking to - has been talking to - software vendors trying to get a feel from any of those billing companies to see what their thought is. And how big of a daunting task this may be or whether they're just like us kind of walking into this wide-eyed and open and trying to figure out where they're gonna begin?

Pat Brooks: This is Pat Brooks. And I can just tell you that, I think, vendors have been participating in our Coordination and Maintenance Committee meetings. So they're aware of the development issues and the issues about ICD-10 - so they're aware of that. And we have gotten comments from them as part of the formal rulemaking.

Beyond that, what I would do is just what Sue encouraged you to do. If you have a vendor, maybe you should just initiate dialogue with them - if they're aware of ICD-10, if they're preparing to do something about it. So I'd be a little proactive with the people that, you know, I work with.

Deborah MacLachlan: Okay. And I have done that. I just wondered if there was a list out there, at this point, of software vendors that were saying we're ready, we know what's going on. I have a concern, honestly, about mine and whether they're really going to still be in business, to be quite honest with you, when this occurs. So that's why I was just wondering if there's anywhere to go or what you've been hearing from those folks.

Pat Brooks: Well, this is Pat Brooks. And I can just say to you another issue we have to clarify is that we have just issued a proposed rule; we're evaluating

comments. We have not put out a final rule and until such things as that happen - and until such time if there's a definitive date to move forward - I think that probably a lot of people aren't sure of their timelines yet. So I don't believe it'd be possible for many of them to have a firm timeline yet.

Deborah MacLachlan: Okay. Thank you.

Ann Palmer: Thanks.

Operator: Your next question comes from Catrice Tate. Your line's open.

Catrice Tate: Thank you. I needed to get clarification - our office deals with physician office visits and then we also do inpatient care. So, is my practice going to need to still work off of the ICD-9 for the office and then we'll still have to implement the ICD-9 -10 or ICD-10 - for the inpatient? I'm going to be working off two different diagnosis, you know, books? Or, you know, I'm not quite sure how is that valid? But that's how we're going to have to do it?

Pat Brooks: Well, Catrice, this is Pat Brooks again. What we propose doing, as a proposed rule, is that we would have a certain date that we would select - would be the implementation date. So, if you saw patients in your office on that given date and that was the implementation date for ICD-10 - on that given date - you would start coding all your claims in ICD-10. And prior to that date, you would code all of your encounters in ICD-9-CM.

That's what we proposed. We thought that was less confusing, just as you mentioned, than having you decide to code one or the other system. So, what we've done is proposed - for encounters on a certain date - we would do the switch to ICD-10.

Catrice Tate: So when it implements and it goes forward, I will just start with ICD-10?

Pat Brooks: Yes.

Catrice Tate: ...with everything?

((Crosstalk))

Pat Brooks: ...with that date of service. Now, obviously if you're behind on your coding by, say, two or three weeks...

Catrice Tate: Uh-huh.

Pat Brooks: ...then you will continue based on what we proposed - coding with the ICD-9 for date of services prior to the implementation date. But once you've got to the given implementation date, you would forevermore be doing ICD-10 - that's what we've proposed.

Catrice Tate: Okay, even for regular office visits and all that?

Pat Brooks: For all settings, and let me just clarify that again.

Catrice Tate: Okay.

Pat Brooks: Since it would be a HIPAA standard, as Donna Pickett went over, then what we've proposed is, for all settings that use ICD-10-CM - and that's every-body - on the given implementation date, everyone would switch.

Catrice Tate: Okay.

Pat Brooks: For hospital inpatient, this switch would occur for hospital inpatients. Also, date of discharge for the ICD-10-PCS only. And, once again, it would not affect CPT or alphanumeric HCPCS.

Catrice Tate: Okay, thank you.

Operator: Your next question comes from Jessie McGrant. Your line's open.

Jessie McGrant: During the presentation, I saw that the ICD-10-CM had left and right included. Does that mean that the modifiers will be discontinued?

Pat Brooks: I believe you're talking about the modifiers on HCPCS and CPT codes?

Jessie McGrant: Correct.

Pat Brooks: We proposed no changes for that.

((Crosstalk))

Jessie McGrant: Even though it's included on the ICD-10 description?

Pat Brooks: And what I can say to you simply is that the diagnosis - when one examines data on diagnosis codes - one - we'll be able to tell whether it's left or right on the diagnosis. We have proposed no changes on the HCPCS and CPT and modifier coding.

If there were to be changes, you would get that separately through separate rulemaking or updates to payment systems. But as right now, we propose no changes to that CPT modifier coding.

Jessie McGrant: I have another question. The HCFA-1500 does not accommodate seven digits for the ICD-10. Will that be also changed?

Pat Brooks: There was another rule that went out at the same time proposing a shift to 5010, a new system that has more ability to put more codes in it. We are also examining comments on that system. So you are correct, it's sort of a two-part process. It's the system - billing systems - issue. And what we're talking about today is purely focused on the coding issue. But you may want to go to our website and, if you're interested, you can review the 5010 proposed rule.

Jessie McGrant: Thank you.

Operator: Your next question comes from Martha Redding.

Martha Redding: Yes. I work in long-term care and I foresee that maybe this is going to be a little bit more help for coding in long-term care. And I also wanted to ask if I don't see any supplemental classification of V and E codes - so will this system be able to help us capture the episode of care after they come from acute care?

Donna Pickett: This is Donna Pickett. In ICD-10-CM, there is a parallel chapter for what is the V codes in 9-CM and the E codes, the external cause injury codes, in 9-CM. So, yes, those concepts are included in ICD-10-CM.

Martha Redding: Oh, great. Thank you.

Donna Pickett: You're welcome.

Operator: Your next question comes from Tish Fraiser. Ms. Fraiser, your line is open. All right, no response, moving on to the next question...

Ann Palmer: Thank you.

Operator: We have Amy Chow next.

Amy Chow: Thank you. Two questions. The first one is for Pat. On Page 33, you mentioned that MS-DRGs are being converted to ICD-10. What exactly does that mean? Are we going to be doing away with MS-DRGs?

Pat Brooks: No. What that means is that if we move to ICD-10, in whatever the given year is, you'll be sending in ICD-10 codes instead of ICD-9. Well, obviously we need to have the logic of MS-DRGs work equally well on ICD-10 codes.

Amy Chow: Oh, okay.

Pat Brooks: So we're starting early just to - sort of as an experiment - to see how well we can convert that payment system.

Amy Chow: Okay.

Pat Brooks: Different payers, I think, will be using our mapping to do with it in other areas or for coverage decisions. And this is purely an exercise to show how well the mapping is working - to see if we need to do anything in addition.

Amy Chow: Okay.

Pat Brooks: And it probably would be good if you reviewed the September 2008 Coordination and Maintenance Committee handouts because it goes into a great detail and gives you good pictures of what all we did. I know it's hard for me to explain in words to you over the phone.

Amy Chow: Okay, thank you. Does it - have you seen any - I guess, reimbursement impact?

Pat Brooks: The reimbursement impacts, if what you mean is, are we able to group the generic codes into the same MS-DRGs...

Amy Chow: Right.

Pat Brooks: ...so it wouldn't have a payment impact...

Amy Chow: Uh-huh.

((Crosstalk))

Pat Brooks: ...so far we haven't had a problem that would lead to payment problems and that's...

Amy Chow: Okay.

((Crosstalk))

Pat Brooks: ...in other words - let me say it differently - if you coded the same case, digestive case, in ICD-9 and ICD-10, do they go on the same DRG? Yes.

Amy Chow: Okay.

Pat Brooks: Now, will that be true to the whole MS-DRG system? I don't know yet, but we'll be discussing that through the Coordination and Maintenance Committee.

Amy Chow: Okay, thank you. And my second question is for Sue. On page 61, you were reviewing the training and the education timeframes and you mentioned two to three days for ICD-10-CM. And I believe also two to three days for the PCS piece as well, so that's four to six days in total?

Sue Bowman: Yes. We're essentially looking at probably about a week - meaning five business days - so probably two to two and a half days on 10-CM. We actually think two is probably going to be adequate because the structure and a lot of the rules and things are very similar to ICD-9-CM.

And then, in the way the participants in our testing project worded it, is they sort of wanted a day of theory - kind of an expanded version of what Donna did during today's presentation - and then a day of application. And then, we're thinking that because 10-PCS is quite a bit different from the ICD-9-CM procedure system - that might take a little bit longer, a little bit more education, so we were thinking probably about three days for that.

Amy Chow: Okay, and you also mentioned that there was some type kind of training, non-interactive training that only took two hours and the people - the testers - are able to start using the ICD-10 without much problem. What was that two-hour training for?

Sue Bowman: That was for the participants in our ICD-10-CM testing project. None of them, of course, had any prior ICD-10 coding experience. So they required some level of training to just participate in the project.

And so they received an audioseminar-type of - similar to this kind of program - of a two-hour program - to - by the National Center for Health Statistics staff to teach them the basics of coding and the different chapters. And then we did do a validation of some of their coding to see how accurate

they were, and since they were really just coding cases back in their own records. And it was surprisingly accurate considering they had not had a great deal of training.

Of course, everybody thought, you know, to really learn the system and do really well when it's implemented, you would need more than two hours. But they actually got enough out of that two-hour session - as far as what the differences between ICD-10-CM and ICD-9-CM were – that, in most cases, they were able to figure it out.

Amy Chow: And that they could go back and start coding using ICD-10?

Sue Bowman: Yes.

Amy Chow: So it may not take the two or four to six days then?

Sue Bowman: Right. But they all felt like, you know, they would have like to had more training - it just wasn't possible within the structure of the project but...

Amy Chow: Okay. Okay.

Sue Bowman: It was amazing how well they did with that limited amount of training.

Amy Chow: Okay.

((Crosstalk))

Amy Chow: Well, that's good to know.

Pat Brooks: This is Pat Brooks. And maybe if you're curious, what you also could do - because we do have some training manuals and things on our website - you could go to our website. And the whole coding system is there and you could just pick some records in your hospital. And see what your review - how it works, how difficult you think. And I think Sue and AHIMA would be happy to hear insights from people on the level of training you think. They will, I'm sure, be getting that kind information later from actual users.

Amy Chow: Thank you.

Operator: Your next question comes from Gwen Toni. Your line is open.

Gwen Toni: Thank you. We work with home care and hospice agencies and I haven't heard them addressed.

The other question I have that sort of goes along with it, you know, you mentioned about, you know, being HIPAA compliant. And I know that you can make Medicare and Medicaid follow these but, you know, a lot of the private insurers have their own companion guides and things that they tell you they have to do. Will they be mandated that they must change to the ICD-10? And, I guess, those are my two questions. What about home and community-based care and their trainings? And, you know, all of the payers being required to make this change?

Pat Brooks: This is Pat Brooks, and I really have to clarify that this will be a HIPAA standard, so that applies to the entire country - all users, all payers, everyone.

If the final rules goes out at - picks a selected date - then everyone must convert to ICD-10 for encounters that occur on that day, and that would include home healthcare and hospice. And on the issue of guidelines in the

proposed rules - we are also proposing that the guidelines that go with ICD-10-CM and PCS become the official coding guidelines, just as they were the guidelines with ICD-9 - were the official coding guidelines. So we have solicited comments on that, but that's what we did propose.

Gwen Toni: Okay, were you - when you set up this program - were you expecting home care and hospice to sit in on this also?

Pat Brooks: Yes. I think all provider types were included on this - on this particular call - and then some...

Gwen Toni: Okay.

((Crosstalk))

Gwen Toni: I was just wondering. I guess I hadn't heard anyone mentioned them and I was wondering if they were represented or not. Thank you.

Operator: Your next question comes from Patty Zorcheck. Your line's open.

Patty: Good afternoon. We're actually a mobile IDTF, so we're Part B providers. We were wondering how this change is going to affect our billing of service performed in inpatient hospital type settings?

Pat Brooks: This is Pat Brooks, and you said you - do you use both ICD-9 diagnosis and procedure codes now or...?

((Crosstalk))

Patty: ICD-9, yes.

Pat Brooks: Okay. Well, do you use ICD-9 diagnosis now?

Patty: Uh-huh.

Pat Brooks: And if the HIPAA rule goes out to name ICD-10, then you would convert on the date of service to ICD-10 - if that is your question? And the outpatient or ambulatory coding system, CPT and HCPCS, as we mentioned earlier, that will continue to be used.

Patty: Okay...

((Crosstalk))

Pat Brooks: ...in the outpatient ambulatory setting.

Patty: Okay, thank you.

Operator: Your next question comes from Christy Conerton.

Christy Conerton: Yes, I just want to clarify that the one that is going to affect first is for professional charges seen in the hospital setting, place of service 21 - we would then be required to use the ICD-10 codes?

Pat Brooks: This is Pat Brooks. I guess I don't fully understand your question. Let me just state it this way, and we'll see if we all understand each other. If you are currently - no matter what your setting - you're reporting diagnosis codes, then you currently are reporting ICD-9-CM. If ICD-10 is adopted on a certain date, then at that point - for those encounters on that date - you would convert to ICD-10-CM...

((Crosstalk))

Christy Conerton: ...if it's a service, once this is actually confirmed, then they set a date?

Pat Brooks: Yes.

Christy Conerton: Okay. But we don't have any idea yet of that date?

Pat Brooks: No, that's true because we have only a proposed rule out. We're evaluating those comments and until such time as there's final rule, we won't know when or if we're implementing ICD-10. So that decision would be made through the formal rulemaking - through a final rule.

Christy Conerton: Okay. I work for a billing company and we're the vendor. So I'm trying to get a timeline of what we need to do, from a vendor standpoint and from a billing standpoint for large corporations, to make sure when this does happen that we're ready.

Pat Brooks: And, you know, what I would encourage you to do is to check our ICD-10 website.

Christy Conerton: Uh-huh.

Pat Brooks: And if a final rule goes out, whenever it does, then we would post information there and then you would know and the rest of the country would know what date has been finalized. And then you are correct - that one can't do definitive timeline planning until you know a definitive date of implementation - and that has not been set yet.

Christy Conerton: Okay, thank you very much.

Operator: Your next question comes from Karen Clark.

Karen Clark: Hi, thank you for taking my question. I missed part of the last answer, and I apologize. But my question was not what the implementation dates are going to be, but when do I anticipate the final rule being published?

Pat Brooks: You know, I have no information to share with you on that.

Karen Clark: Okay. Thank you.

Operator: Your next question comes from Barbara Hook.

Barbara Hook: Yes. Thank you. When the final rule does come out, how much time before we will actually have to implement?

Pat Brooks: And, once again, that would be in the final rule - so none of that has been decided yet.

Barbara Hook: Are we looking at three to six months, or one year, or two or three days?

Pat Brooks: Well, you know, I can't imagine anything would happen in two or three days. I don't think anything works that fast.

((Crosstalk))

Barbara Hook: I know that's exaggerated but...

Pat Brooks: But what I have to tell you is - since there's no final decision - I can't give you a projection of how many years it would be, you know, but a date would be picked and that would be in the final rule.

Barbara Hook: Are we looking at maybe in 2009 or are we looking at the final rule might come later on that we have a little bit of time to get the…? I've talked with other doctor's offices and a lot of them are not even aware of the ICD-10 at all.

Pat Brooks: The only thing I can tell you is the proposed rule proposed an implementation date of October 1, 2011. We don't know when the final rule will go out or what the final date would be - that we would establish to implement - but that would be included in the final rule. I understand your anxiety but, at this point, those comments are being carefully evaluated and considered here within the Department.

Barbara Hook: Thank you so much.

Sue Bowman: And, this is Sue - I just want to add to that and I think Nelly also mentioned it during her presentation - that we really, really are encouraging people to get started even though we don't know when the final rule is going to come out, we don't know what the implementation date is. There's, you know, there is no reason to waste this precious extra time that we have right now, so educating people who are not aware of ICD-10 and starting to look at the systems and other things that I mentioned during my presentation.

We strongly encourage people to get started with some of those activities because no matter when the implementation date is, that time and effort will not be wasted. And you'll be that much further ahead.

Operator: Your next question comes from Kelly Porter.

Kelly Porter: Hello, I actually have a question about - I see that there's a pattern when it comes to the ICD-9, 10 codes. The first one is the alpha, the second one is the

numeric. So I was just wondering for the rest of the code, I mean, for the rest of the digits - is it - is there any pattern to how they're gonna be or is it just a matter of the code?

Donna Pickett: This is Donna Pickett. You are referring to the diagnosis codes?

Kelly Porter: Yeah, because like the - I'm not sure who was talking about it - but they were saying that the first digit is gonna to be alpha, the second one's gonna be numeric, but then the - then that - I mean all the other ones are gonna be either alpha or numeric. So I was just wondering is there any pattern of how they're going to be set up or is it just depending on the code?

Donna Pickett: It does depend on the code - you are correct.

Kelly Porter: Okay. And then my second question is, if all these other countries - because I actually just got out of school in October so, I'm brand new to this - if all these other countries have been implementing this for such a long time, how come the United States hasn't implemented in following with everyone else?

Pat Brooks: This is Pat Brooks. That's an interesting question - a lot which is discussed in the proposed rule. I guess I don't have the simple answer for you, but I can suggest one thing to you since you're a recent graduate and you are interested in the structure of ICD-10-CM and probably PCS. You should go to our website and you can open that file and you'll see a picture of what looks like the code book. And that helps a lot - you can actually see the tabular make-up of these codes. It might be a little more clear - what it relates to.

Kelly Porter: Okay, thank you very much.

Operator: Your next question comes from Rachel Hanna. Your line is open.

Rachel Hanna: Okay. I'd like to follow up on the home health and hospice question that was asked earlier. I believe it was Sue Bowman who addressed the testing that occurred in a variety of settings. I wanted to know - was the testing in the variety of settings - was one of those settings a home health or hospice setting?

Sue Bowman: This is Sue and, yes, it was. I don't have the report right in front of me. You can actually download the report from AHIMA website, which gives a lot of details of the demographics of the people and providers involved in the project. I do recall that there were home health agencies included in the testing.

Rachel Hanna: And what website - in terms of - you said it was the AHIMA website?

((Crosstalk))

Sue Bowman: The - www - it's on actually one of my slides - the website - but it's, www.ahima.org.

Rachel Hanna: Okay.

Sue Bowman: If you search for ICD-10-CM field testing, you will be able to get to the actual final report of the project and it gives a lot of details about the - it has some graphs and things – actually, of the different provider settings that were included in the study.

Rachel Hanna: So, does the report also contain like the number of home health and hospice agencies that were involved in this project? Is that part of the data?

Sue Bowman: I believe that it is.

Nelly Leon-Chisen: This is Nelly. If I may provide a little bit of assistance - because I have the benefit of being in front of a computer. It is on the report and it refers to place of employment. It's on page 17 of the report because I'm thinking that you might wanted to take a look at that in more detail. But home health and hospice were lumped into the same category, and it was 0.6 percent of the participants were employed by home health or hospice.

Rachel Hanna: Okay.

And then I had another question related to - there was some information in the presentation related to training. And that I guess some of the entities involved in this project would provide training? Will there be setting-specific training available? For instance, particularly, for the home health and hospice industry?

Sue Bowman: This is Sue, and we haven't fully planned out all of our products and resources. And there will obviously be a lot of organizations and vendors out there who will also be developing educational products, so that's hard to say.

I would guess that there would be and I would guess that even some of the home health association and other sources might also have products available.

But, for certain, we are looking at the variety of different settings and groups of people who need training and need different levels of training, and trying to develop targeted resources for those groups. And, as I've said, we know that there's going to be a lot of organizations besides just the ones on this call today who will also be developing educational materials, so it's a little early yet to say exactly what all of those will look like. But I'm guessing there will be a multitude of them.

Rachel Hanna: I was just really curious from the standpoint of the people involved in the project - like such as your organization and other ones - if they were thinking about developing targeted resources?

Sue Bowman: We definitely are, and are looking at economical ways of producing those sorts of things. And making them available such as web-based products, which can be made more available to a wider group and have a longer shelf life because they're easier to update. So we are looking at all of those kinds of issues.

Rachel Hanna: Okay, thank you.

Operator: Your next question comes from Lisa Scott Lee.

Lisa Scott Lee: Good morning, actually, this is Dr. Lisa Scott Lee, Sacramento California Department of Health and Human Services, Division of Mental Health. And thank you again for your presentation. I also want to thank Donna Pickett for receiving my call earlier in the year.

You stated earlier about the harmonizing between the DSM IV. Our concern in California was between the DSM V. We know that the DSM V is going to be released over a year later after the proposed date for the date of implementation for the ICD-10-CM.

We have some concerns about that. We also were curious about, specifically, those coding issues where the crosswalk from one DSM to many ICD-10-CMS - CM - diagnosis because we don't want coders to make that decision, but clinical physicians and staff to make the one-one correlative, you know, that sort of decision.

So, an earlier question was raised about vendor's readiness for - from an IT perspective - of putting this into effect. So we're wondering if that has been addressed and is there any possibility of more of a release date that coincides with the DSM release date for DSM V? Thank you.

Donna Pickett: This is Donna Pickett. Thank you for the question. In relationship to DSM IV and Chapter 5 of ICD-10-CM, CDC worked very closely with the American Psychiatric Association in harmonization, and we continue to have an ongoing relationship with APA as they look toward moving to a DSM V.

However, that work is still ongoing. But at the point that there is a more formalized version of DSM V, APA will be working with CDC in bringing into 10-CM any of the relevant changes, and concepts, and terminology - just as the APA has always done in working with CDC in harmonizing DSM IV - not only with ICD-10-CM, but also with ICD-9-CM.

Lisa Scott Lee: Thank you, Ms. Pickett. I appreciate it.

Donna Pickett: Okay.

Operator: Your next question comes from Kim Tat.

Kim Tat: Yeah, I was curious to know about how this ICD-10 is going to equate to the ambulance condition codes that are being used - if you have any discussion about that yet?

Pat Brooks: This is Pat Brooks. The ambulance condition codes are not ICD-9-CM, is that correct? You'll have to help me with this.

Kim Tat: They're using ICD-9-CM as a backbone to determine what condition code it would fall under. So, yes, they probably would be moving in the direction of ICD-10, I would suspect.

((Crosstalk))

Kim Tat: That currently they are not mandatory. They're only voluntary. But there are many ambulance companies who used them for a lot of various things.

Pat Brooks: Then the way I'll respond to you is - once the ICD-10 is implemented, at that time, then those codes would be used in all payment system. And I would assume that there were any updates of payment, if they were used as either your codes or whatever, that would go through rulemaking in the ambulance area. If they were to be mapped to a particular code, whatever the given date is, instead of being mapped those generic ambulance condition codes - instead of being mapped out to ICD-9 - and at the point of where we implement ICD-10, they would need to be mapped to ICD-10-CM.

Kim Tat: Okay.

Operator: Your next question comes from Nancy Lynch.

Nancy Lynch: Hello. Good afternoon. Thank you for taking my call. I appreciate this teleconference. It's been very informative. I actually had a question - I think that someone had asked earlier about, you know, how the payers are preparing for this type of transition as well.

Pat Brooks: This is Pat Brooks, and as far as us a payer, Medicare, we're just - and we're - analyzing internally the impact it would be for us to move to ICD-10. As far as any updates, any particular part of CMS, we have formal rulemaking. So if

we move to ICD-10, it would be handled in that particular payment system setting - how they would convert those ICD-10 codes.

Other payers, until we have a formal date, I'm not sure they can tell you exactly how they plan to move forward, but I am aware that - in - many of the other payers are aware of ICD-10 and they have formally commented on it and on the timeline. So they are evaluating the issue.

Nancy Lynch: Okay. All right, thank you all for your time.

Ann Palmer: Okay, Ken?

Operator: Yes, ma'am.

Ann Palmer: We'll take one more call.

Operator: One more call - that will come from the line of Jen Metones.

Jen Metones: Yes, I just have one simple question. Attending this audio conference versus the November 17 - what's the difference?

Pat Brooks: The only difference will be the questions raised in the open part at the end.

Jen Metones: Oh, that's about it - basically it's - I mean, we're in physician office. We also do inpatient billing, so we don't need to sign up for the November 17, correct?

Pat brooks: No, because you're going to hear the same slides and the same presenters.

Jen Metones: Okay, great. That's all - all the other questions were the ones that we were going to ask, but they were all answered. Thank you.

Ann Palmer: Okay and thank you for your participation.

Operator: Would you like one more question?

Ann Palmer: No, that will be it for now. Thank you very much.

Operator: Thank you very much. This now concludes your conference call. You may now disconnect.

END