TRANSCRIPT SUMMARY

Centers for Medicare & Medicaid Services
ICD-10-CM/PCS Medicare Severity-Diagnosis Related Group Conversion Project
National Provider Conference Call
Moderator: Ann Palmer
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Operator: Welcome to the ICD-10-CM/PCS Medicare Severity-Diagnosis Related Group Conversion Project National Provider conference call. All lines will remain in a listen-only mode until the question and answer session. Today's conference is being recorded and transcribed. If anyone has any objections you may disconnect at this time. I'll now turn the call over to Ms. Palmer. Ma'am you may begin.

Ann Palmer: Thank you. And as Amanda said, I'm Ann, and I will be moderating today's conference call. Please note that this call is being recorded and will be transcribed. The written and oral transcripts of this call will be posted shortly. Also, please note that the presentation that we will be discussing today has been revised. You can find the revised presentation and call transcripts on the Internet at www.cms.hhs.gov/icd10 . On this Web page select 2009 CMS Sponsored Calls from the left side of the page. The presentation is posted in the Downloads section. Our first speaker today is Pat Brooks, who is a Senior Technical Advisor at CMS. Pat is going to provide an overview of the project and some detail about the first stage of the conversion project. Go ahead, Pat.

Pat Brooks: Thank you, Ann. I will be covering the MS-DRG conversion project today, the stage 1, and Mady Hue will be going through stage 2 of this project. But before I get into the project, I wanted to give a brief overview of the new requirement to move to ICD-10. And if you look at slide 3, you will see that we published an ICD-10 Final Rule on January 16th 2009. And the important date to note in that final rule is that October 1, 2013 will be the compliance date for the implementation of ICD-10-CM, Clinical Modifications, which are the

diagnoses, and ICD-10 Procedure Coding System, PCS, which are, obviously, the procedures. And we've provided you on slide three a link that you can go to if you want to read that final rule.

Turning now to slide 4, some of the important issues that were covered in that final rule include, first of all, that we are going to have a single implementation date for all users. And that date will be for date of services for ambulatory and physician reporting and date of discharge in the inpatient settings. So, ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013. At that time services should be coded with ICD-10. Now, we do recognize that many payers, such as ourselves at CMS, will continue to receive ICD-10-CM coded claims after that date, as claims from a prior period flow through. So we will be processing both ICD-9 and ICD-10 codes but we'll be looking at the date of service to see if they are correctly coded.

Slide 5 gives you some very good resources. We've done a number of outreach and educational activities so far. CMS collaborated in developing some materials and producing some prior outreach conference calls with the American Hospital Association, the American Health Information Management Association, and the Centers for Disease Control and Prevention. And these four groups are recognized as the Cooperating Parties for ICD-9 and ICD-10. And to see that prior material, I've given you a Web page for Educational Resources. We have several fact sheets that people are finding quite useful that give you an overview of what ICD-10 is all about. We also describe the topic we're discussing some today, which is mappings between ICD-9 and 10 – the General Equivalence Mappings – which I'll be getting into later. There's informational fact sheets on those. In addition, we've held prior calls and you can see some for 2008 and 2009 – I've provided the 2009 link. For those of you who want more detail about the use of the General Equivalence Mappings, I'll refer you to a call that's posted on that website where we did give much more detail in how to use the mappings than we will be getting into today.

Moving on to slide 6, first of all, as many of you know who have already looked at ICD-9 and listened to our previous outreach calls – ICD-9 and ICD-10 codes are quite different. And because they are different, then tools are needed to help providers and payers to convert data from ICD-9 to ICD-10. CMS developed what we refer to as the General Equivalence Mappings, the GEMs, as a tool to aid in converting applications from ICD-9 to 10. And we will note that they are also bi-directional. They'll go from 9 to 10 and 10 back to 9. You can use these – this tool – these GEMs as a sort of a find and replace for codes, a list of codes, as you want to convert data.

Slide 7 is a visual representation of what I mean by the GEMs being bi-directional. If you have an ICD-9-CM code that you want to convert to ICD-10, then you would use the forward mapping file. If you have an ICD-10-CM code and wondered what code or codes were the predecessor codes, then you would use the backward mapping file. And for more detail about the use of those mappings, I once again will refer you to our fact sheets, and for the call we'll wait and discuss the GEMs.

Slide 8 is a slide that describes the project we're talking about today – the ICD-10 Medicare Severity Diagnosis-Related Group – that's MS-DRG Conversion Project. And for those of you who don't work in a hospital now, I'll just let you know that MS-DRG is the payment units we use for inpatient Medicare reimbursement. We developed a paper on this whole conversion project we're talking about today, and we posted it on our website. And I would urge those of you who haven't seen it to be sure and pull this up and read it later. Mady and I will be giving you only a very high level overview of the work that was conducted and referring you to things on the Webpage. But for detailed information, I think that you'll find that the paper provides a great deal of that information.

Moving on to slide 9, the question is sort of why did we conduct this project? Why did we convert the MS-DRGs to ICD-10? Well, firstly, when we developed the General Equivalence Mappings, many in the

industry wondered how well that tool would work when we needed to begin converting something – short or long list**,** payment systems, edits, whatever. CMS decided that we would approach this task, if you will, by picking our most complicated payment system – the MS-DRGs – once again, that's the inpatient Medicare payment system. We would – see – use those GEMs to see how well they worked in converting that DRG system to ICD-10. We announced to the public we were going to do this in several stages. And the first stage was that we would pick one part of the payment system. And that was the part that had to do with the digestive system, or MDC 6, parts of that DRG and we would attempt to convert them. We would present the results at September 24, 2008 ICD-9-CM Coordination and Maintenance Committee or the C&M meeting we call it in shorthand. This Committee is a public meeting that discusses updates to ICD-9 and ICD-10, and each meeting has a section devoted to ICD-10 activities. CMS said that we would share what we learned about this conversion project with the public. And I'll be discussing the presentations through stage 1 today.

Looking at slide 10, you will see that our conversion goal for the MS-DRG was to, frankly, convert the ICD-9 based payment system, the DRGs, to ICD-10. Our goal was that, to the extent possible, the same patient who got the same care, who if they were coded in ICD-9 or in ICD-10 – they would be assigned to the same payment group. So, I want to be quite clear about that – our goal was to keep the payment system, for the most part, the same. It wasn't to improve it, consolidate it, or refine it. It was to convert this payment system to ICD-10 codes and, to the extent possible, keep the system the same. Now, others may have conversion activities that are different. Their goal may be to convert a list of codes and to better refine the list. For instance, maybe a coverage edit instead of having the same patient being screened for the same coverage area – the goal might be to improve and the accuracy of that list that describes what's covered and not covered. So, before you begin a similar project, you will have to decide when you're using the GEMs: do you want to convert it so that the patients are the same, the results the same, or do you want to

maximize the way you capture the narrative description of whatever those diagnoses – the conditions – those procedures performed. And, once again, our goal was to keep the DRGs basically the same. On slide 10, for those of you who've seen the Definitions Manual – you'll see that when we tried to post these, we tried to make them not only clinically equivalent but we wanted our Definitions Manual to look the same. And the Definitions Manual is simply a book that describes what codes are in a particular payment group.

Turning to slide 11, we will illustrate in a very simplistic manner how we went about updating the DRGs from ICD-9 to ICD-10. And one example on this page – page 11 – shows DRGs 385 to 387, and it's an inflammatory bowel disease. And under that we have four diagnosis codes listed – four ICD-9-CM diagnosis codes listed. So when one converts that payment group – that DRG – to ICD-10, you need to find the equivalent ICD-10-CM diagnosis codes and replace them. You'll notice this slide shows that for those four ICD-9-CM codes, we replaced those with the equivalent 28 ICD-10-CM codes.

Turning to slide 12, we did a similar type of finding and replacing for the procedure codes for our surgical payment groups, our surgical DRGs. And on the left of this slide, you'll see codes for lysis of adhesions and there were two of those. ICD-10 has much more precise codes that tell in more detail how you go about lysis adhesion and where the adhesions are. And for this reason, we replace two ICD-9-CM procedure codes with 112 ICD-10-PCS codes.

Slide 13 gives a summary of – the – what happened in our first stage, stage 1, of this MS-DRG conversion process. And for those of you who are beginning a single process, I'll tell you that it's been our experience so far that one of the most difficult things upfront in converting big systems is you have to identify the codes you want to convert. And in our case, we had lists of codes that go with individual payment groups or exclusions and procedure groups. We've identified about 200 lists of diagnosis codes in the Medicare MS-DRG system and 300 lists of procedure codes. Once you find those lists, those are

the ones that need to be converted to ICD-10. So we had a total of about 500 lists of codes. Using the General Equivalent Mapping, which gives us a general code that's an equivalent between one or the other, we were able to convert about 99 percent of the diagnosis codes using the GEMs. So one percent, we had to read the narrative description, look at the DRG, and do some independent analysis to decide how to convert that one percent of the codes. On the procedure code lists, we were able to use the GEMS, the mappings, to convert 91 percent of the procedure codes so there was a greater number – about nine percent of the procedure codes – where we had to do some analysis. And I'll show you the kind of analysis that we had to do. The reason that the GEMs didn't work as well in automatically converting procedure codes, as I'm going to show you in a moment, there are many procedure codes that are quite vague or broad and, too, it was difficult. You have to look at them and see what part of the body system you're dealing with so you understand how you're going to convert the DRG.

I think its best just to show you an illustration of that through slide 14. We have a list of about 200 codes that we consider overly broad codes. And if you look at the block on slide 14, the first one on that list is Implantation or Insertion of Radioactive Element, code 92.27. Well, you can see from that code that you have no idea what part of the body that element is put in and you don't really know how you got the element in, what approach was used. Other examples from that list include code 39.31, Suture of an Artery. You can't tell what artery was sutured – what part of the body – and, obviously, that can make a big difference in a payment group from Medicare. So, we do have this list of overly broad codes and we had to make a decision that if you have these overly broad codes, do you find all the equivalent codes in ICD-10 PCS and substitute that – those – all that extensive list into payment group or not? And because the ICD-10 PCS codes specify the body part, the approach in any device used, for code 92.27, we found 261 PCS codes that were equivalent to that one code for the insertion of radioactive element.

If you'll turn to slide 15, you'll see what we did about this particularly overly broad code. As I said earlier, our stage 1 was dealing with the digestive system and when we looked for the code for radioactive element, we found them in a set of three diagnosis-related groups – three DRGs – the three payment groups. When we found the comparable codes for code 92.27, we found that there were 261 PCS codes but, frankly, only 10 of these codes appeared to apply to the digestive system. And you'll see at the bottom of slide 15 that, obviously, insertion of a radioactive element into esophagus or the rectum would be considered digestive system, so they should probably go under that same payment group. But when you insert a radioactive element into the eye, the lung, or the breasts, that's clearly not digestive system so for that payment group we didn't include all 261 codes. We included only ones that related to the digestive system.

Slide 16 shows you another general approach we used to working out code conflicts. Sometimes an ICD-9 code kind of has more than one ICD-9 predecessor codes. And if all those predecessor codes, in the case of the DRGs, the inpatient payment system – go in the same payment bucket, then you're fine. You can map all the codes to the same place. But in this particular case, the ICD-10 code for rheumatic heart disease had two predecessor ICD-9-CM codes and they went into two separate payment group categories. So, the new code, ICD-10-CM, can only go in one place. And the choice is – do you put it where the predecessor code 398.99 went, which in our case happened to be DRGs 314 to 316, or do you put that ICD-10-CM code in the place where 397.1 was, which was a different set of DRGs – DRGs 306 and 307? We decided to resolve that code conflict by placing the new ICD-10 code where most of the cases for the predecessor code went. And our data showed that most of the Medicare patients were coming from code 397.1; therefore, we mapped the new code to the same DRG where 397.1 went, which was DRGs 306 and 307. And for those of you who want more details about this, you'll find much more information about this, or perhaps a better explanation, in our MS-DRG paper that I referred you to earlier.

Now, slide 17 talks about how we've tried to keep this whole process of developing the GEMs, using the GEMs to convert them, updating them. We've tried to keep this very open and transparent. We announced our goals of doing this project at the Coordination and Maintenance Committee meetings, and we've discussed it at each meeting as we've gained progress. We announced that we would have a draft Definitions Manual – that's the list of codes that would go into each DRG in 2009 – and we have done all that, as Mady's going to discuss with you shortly. But I need to point out that this project we're describing today was simply an exercise to determine how well we could use the GEMs to convert the MS-DRGs and to learn lessons that could applied by others in the industry who had similar conversion activity to do. So, even though we are sharing information of our conversion process, this is not the final MS-DRG logic with ICD-10. The final version of ICD-10 MS-DRG logic will be subject to formal rulemaking and so we will go through that process prior to the final implementation. We will have a proposed and final rule where people can formally comment on that DRG logic. We believe that that process will go so much better since we've shared with the public early on how we approached this whole project.

On slide 18, our findings to date are that, frankly, the GEMs have worked very well in converting codes. As you saw from the slide, from the MDC 6 – the digestive system conversion – about 95 percent of the codes in our inpatient payment system could be converted using the map without having to review, study the logic, look at the codes, and make independent decisions. And then in stage 2, Mady's going to talk about how through rule development and then the number of codes that need review can decrease. We also learned that automation for some of the steps we use in stage 1 were particularly helpful.

Slide 19 – we will – Mady will be talking about stage 2 and she'll describe how CMS completed the MS-DRG conversion to ICD-10. She's going to go over in detail – the approaches – the general approach we used, the staff utilized, automation and refinement of

processes, any generic issues identified and how we resolved them, and the enhancements of the GEMs, as a result of this process what we learned. She's going to give you examples – they're from the inpatient area. For those of you who aren't familiar with inpatient area – but they can be applied to other areas. But we'll be describing lists that we have called "major complication and comorbidities," which are basically high severity diagnosis. And complication and comorbidity conversions, and that's a less serious list of severity diagnosis that we have in Medicare for inpatients. And we'll also briefly describe some work in the cardiovascular section of the MS-DRGs and the musculoskeletal system DRGs. And, more importantly, we want to give advice to the public who are thinking about undertaking a similar project so that it will be easier for them. And that's all I have on my part, Ann.

Ann Palmer: Thank you, Pat. At this time, we are going to open the phone lines for the first question and answer session. Please note that specific coding questions are outside the scope of this call. Amanda, could we please start the question and answer session?

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question, and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking a question so anything you say will be heard into the conference. Your first question comes from the line of Carrie Work. Your line is open.

Sherry Hutchinson: This is Sherry Hutchinson with Florida Health Care Plans. You had mentioned that the final ICD-10 MS-DRG logic is subject to rulemaking and that will be published. Do you have a timeframe when those will be out and do you think they will be finalized through the rulemaking process?

Pat Brooks: Thank you for that question. At this point, obviously, as you know being from Florida – our proposed rules are about April 1 of each year. Our final rules are August 1 of each year. I don't believe that a decision has been made whether that final MS-DRG proposed logic change will be the – which – year before ICD-10 is implemented, whether it'll be the year of it or a year prior. That has not been decided yet. We're hoping, though, by doing all this work early with you so that you can see – what we – how we've done the conversion project, when we do our formal rulemaking for the FY 2014 MS-DRGs, which will be ICD-10 based**,** it'll be easier for you to comment because you've had several years to look through this. But, I don't have a firm fiscal year for which the formal rulemaking will discuss that definition of manual logic.

Sherry Hutchinson: Okay, thank you.

Operator: Again, if you'd like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from Bernice Tramp. Your line is open.

Bernice Tramp: Hi, this is Bernice, and I'm with Avera Sacred Heart Home Care in Yanton, South Dakota. And that bi-directional mapping – is that going to be a website that a person can go onto CMS and find out the conversion from ICD-9 – 10 – or ICD-9 to an ICD-10?

Pat Brooks: Yes, as a matter of fact, we have already posted those mappings on our Web page. And at the end of this talk, you'll see some links where you can find them. And – it's not – it's not a vendor software application. It's simply – it's a list form now so that if you open the list – say you had an ICD-9 diagnosis code you're interested in, you would open the ICD-9 file, find the code you were interested in, and find the code or codes for ICD-10 that were equivalent. And that's there now. And for a better understanding of how that works, I would refer you back to our 2009 website for the outreach calls because we went into great detail about how those GEMs mappings work, and how to use

them, and how to apply them. So that might be real helpful for you. I'm sorry we didn't go through that detail today.

Bernice Tramp: Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from Ann Cherlow. Your line is now open.

Ann Cherlow: Hello, this is Ann Cherlow from Mathematica Policy Research and I was wondering when you said you chose – when you had a conflict – when you said you chose the one that represented more Medicare. Did you mean more claims, more people, more inpatient use, or how? Could you give a little more information on that, please?

Pat Brooks: Yes – that's a – that's a good question. We looked at the number of cases, so we found for rheumatoid arthritis, we would look at how many of one code versus another. So we looked and if they were split by two different codes, then we saw how many Medicare beneficiaries on the inpatient setting reported those codes. And if – and most of the time there was a heavier use of one code versus the other, we mapped our DRGs where we had the most Medicare patients. Now, obviously, if you weren't a Medicare payer and let's say you were concerned with a pediatric application, it's possible that if you looked at codes that mapped to two different codes – predecessor codes – that perhaps some pediatric populations would work differently and you might make a different code selection. So we did want to let people know since we were converting a Medicare payment system – we used Medicare claims data to make our decision about which one was more heavily used or not.

Ann Cherlow: Thank you. Could you say if there an indication on the ones where there's a conflict so you'd know to look where you might have to make a new decision for yourself?

Pat Brooks: Well, I guess if you want to call it a conflict and if you don't work with the DRGs, it's a little bit difficult to explain, but when you look in the General Equivalent Mappings and you find one code is going …

Ann Cherlow: Right.

Pat Brooks: … to multiple codes. And you look at the predecessor codes, the ICD-9 codes, you'll be aware by using the Definition Manual that one will go into one DRG and one will go into the other. And so I guess it takes several tools to see how we approached that, if that's helpful to you.

Ann Cherlow: Sure, thank you.

Operator: Your next question comes from the line of Beverly Stackhouse. Your line is open.

Beverly Stackhouse: Yes, hi, good morning. My name is Beverly. I'm with Caring Hands Home Health Agency. And what I wanted to know is this teleconference based for mostly inpatient community hospitals or is it for hospitals and home health agencies?

Pat Brooks: Well, we provide this for anyone who wants to listen. Because conversion project, obviously those who work on an inpatient setting will understand DRGs much better than for a person who works in the home health. But if you had a desire to convert a home health list of codes, then we opened the call up to all because maybe you'll learn something from this process to make your own conversion – work – work better. But, I think you are probably correct if you said that those who work in the inpatient setting probably will get the greatest amount of information out of this, and our example happens to be an inpatient DRG payment system.

Beverly Stackhouse: Okay, thank you.

Operator: Your next question comes from Kay Dimmitt. Your line is open.

Susie Smith: Yes, this is Susie Smith with St. Luke's Home Health and Hospice. Being home health – are we – you know, our medical coding is built into our home health OASIS software so that leads me to assume that all of the software companies will have to develop their own GEMs within their system so that we can utilize, you know, the coding from ICD-9 to ICD-10, correct?

Pat Brooks: Let me answer that a different way. I'd say that payers such as Medicare and software vendors who have products will need to convert those payment systems and products from ICD-9 to ICD-10. And in order to do that, we've developed this free tool that we've put on our Web page, which is the General Equivalent Mapping. So that depending on how many codes were in it and if it's an OASIS product with a list of codes there, then those can be converted from 9 to 10 using the GEMs. Obviously, you would mainly use the diagnosis part of the GEMs. It would not be a fact, particularly for a Medicare payment for home health that ICD-9 codes would come in. They would be converted to ICD-10 and then go into the right code. After October 1, 2013 home health – everyone – would be coding with ICD-10 so the conversion of these products and systems has to take place in advance of that implementation time so that the logic can be converted to ICD-10 logic, if I explained that correctly.

Susie Smith: Yes, I still – I'm just – I needed to know that your own software company will have to create that GEM within your own product so that it does give you the ICD-10 codes.

Pat Brooks: Well, here's what we will do: within Medicare, every payment system, they will not embed the GEM into the system. They will use the GEM mapping logic to convert the entire payment system – OASIS, quality measures, coverage edits – all of those will be converted to ICD-10 based codes. So the GEMs are tool that will allow us to convert those and then the software application, which will now – in the new one – will contain ICD-10 code. It will recognize the ICD-10 codes and make correct payments or edits. And you know probably, once again, I would refer you for detail of understanding of what the GEMs are and

are not to that call that we had earlier this year where we went in detail about what the GEMs are for and how they're used. I think that will help a great deal in understanding this.

Susie Smith: So there will no longer be a separate coding manual for home health medical coding? It will all be for acute care, inpatient, home health – it will all be one manual, correct?

Pat Brooks: If what you're asking – home health now uses ICD-9 and after October 1, 2013, you will use an ICD-10 coding manual instead? So, yes, you and every other type of provider will switch from using an ICD-9 coding manual to an ICD-10 coding manual on October 1, 2013 for services that occur on and after that date. So, yes, you would need to have new source code for your – a new source coding system for ICD-10.

Susie Smith: No, that's not exactly what I asked. I'm meaning that right now there are two different ICD-9 manuals – one for acute care and one for home health. So will ICD-10 still mean you'll have two different manuals or will it all be one manual for all codes?

Pat Brooks: You know, I think what you're talking about is some publishers have developed code books that they call "home health manuals" or "physician code books." And they edit them and they put different pictures and edits on them, but they all fall back into one national ICD-9-CM coding standard. We have a CD-ROM for that that we produce every year. You can find links on our Web page where we tell everybody in the world this is the official code book for this year. Publishers sometimes do – for physician offices – sell an ICD-9-CM "physician code book" and maybe they'll leave out the procedure codes, but those codes all match. They're all the same codes. Home health – if you bought a book that had a label on the front "home health" – those codes match identically to the codes in the official ICD-9-CM code book. So, if you choose to buy a vendor's code book that is specifically tailored with helpful information for you, you could do that but there will be only one official ICD-9 code system at the date – just like there is now. I hope that's clear.

Ann Palmer: Amanda?

Operator: Yes.

Ann Palmer: Let's go ahead and take one more call and then we'll go ahead and have one more Q & A at the end.

Operator: Okay, just one moment. There are no further questions at this time.

Ann Palmer: Okay then. Now Mady Hue, who is a Health Insurance Specialists at CMS, is going to discuss stage 2 of the conversion project. Go ahead, Mady, please.

Mady Hue: Thank you, Ann. Good afternoon to those of you on the phone. We'll now move to slide 22 and continue the discussion. Basically, the general approach that was used to convert the remaining major diagnostic categories, or MDCs, was the same process that was developed and refined during the MDC 6 conversion. As we heard earlier from Pat's discussion and shown on slide 13, there are approximately 500 defined lists of ICD-9-CM codes for the program logic extraction. So to continue the conversion process for the remaining MDCs, the code lists were extracted and organized into categories, which were then further defined based on certain characteristics or attributes. Any list conflicts that were found were handled and there was an example on slide 16 that Pat described earlier. And I'll discuss additional examples in a few moments. We also looked at the list of the vague ICD-9 procedure codes and assigned them to the correct ICD-10-PCS list according to the anatomic site or body system that corresponds to each MDC. And for the clusters, these were handled by programs that were written to discover which ICD-10 clusters were needed to fully replicate a DRG list. So as you'll see in some of the examples later, for some cases the MS-DRG logic was modified to look for two ICD-10 codes where previously it looked for only one ICD-9 code.

Turning to slide 23, you'll see some of the staff that was utilized. For our project team we had researchers, coders, software programmers –

basically the team consisted of people who had experience with the MS-DRGs, ICD-10-CM and PCS, the GEMs, or all three. So for your own organizations, you'll need people who can write the programs to help automate the process as well as analyze the accuracy of the translated results and then provide clinical validation of the translated lists.

On slide 24, we talk about some of the refinements. In some instances the frequency data was not convincingly strong enough to demonstrate refinement of an ICD-10 code to one list versus another. So we had to seek clinical input to make the most appropriate determination, but the basic method that was used to resolve the MDC 6 list conflicts was the same for all the MDCs. And Pat discussed how we used the frequency data.

Moving to slide 25, some of the efficiencies that were added for stage 2 involved those general procedure codes that we discussed earlier. Because they were so vague, we developed a table and then we reviewed those to assign them to the right system. We had anticipated some of these issues for the other specified procedure codes and ICD-9 that are not specific when you compare them to the ICD-10 PCS code, which provides a lot more detail for the anatomic site or the body system. So the tables were created and the codes were reviewed. And we determined the most appropriate lists.

On slide 26, we talk a little bit about the clusters again. And these are when you have multiple ICD-10-CM or PCS codes that must be used together to fully replicate a single ICD-9 code. So in some cases, again, we needed to modify the DRG logic to look for two ICD-10 PCS codes, where before it might have only looked for one ICD-9-CM code. We also created what was called a "reverse index lookup" and this was basically a tool that helped in discovering all the concepts that could be contained in the code. So if you're familiar with the CD-ROM, the Folio software, it's similar to that process – where you can put in an index entry and it outputs all the associated conditions.

On slide 27, we talk about some of the new issues that were identified with stage 2, where we had ICD-10 codes that included both a CC or an MCC. Some of the codes specified both an underlying condition and an acute manifestation or a complication in the one code. So when you translate it to ICD-9, you saw that you needed two codes – one to describe the underlying condition and another one for the acute manifestation or the complication.

And slide 28 shows an example. So we have ICD-10-CM code R65.21, Severe sepsis with septic shock, and when you translate that to ICD-9-CM you have 995.92 that describes Severe sepsis as well as 785.52 for Septic shock.

Mady Hue: Moving to slide 29, again, when you have an ICD-10-CM combination diagnosis code that might be a "with CC or MCC" MS-DRG, instead of being coded in ICD-9, we replicated the ICD-10 based version of MS-DRGs. So we modified the ICD-10 codes that met that criteria to the appropriate "with CC" or "with MCC" and its DRG.

On slide 30, we have an example. When 415.19, Other pulmonary embolism and infarction, is the principal diagnosis and 415.0, Acute cor pulmonale, is the secondary diagnosis, the 415.0 would act as an MCC in the current MS-DRGs. So when you have ICD-10 code I26.09 that's a combination code, Other pulmonary embolism with acute cor pulmonale is the principal, the MS-DRG logic is modified to assign it to the appropriate "with MCC" MS-DRG solely on that principal diagnosis.

Looking at slide 31, since the project of converting the MS-DRGs was also a test for the accuracy and completeness of the GEMs, it provided the opportunity for further enhancements or revisions. One of the sections identified involves the ICD-10-CM subsequent encounter injury and the poisoning codes, where an updated guideline instructed that the subsequent encounter ICD-10-CM codes are to be used as aftercare and should, therefore, be translated to the "V" codes in ICD-9-CM.

On slide 32, we show an example. Currently in the 2009 GEMs, you'll see S51.011D, the Laceration code, translated to 881.01. In the 2010 GEMs, you'll see that the S51 Laceration code will translate to the V58.89, Other specified aftercare code.

For converting the MCC and CC list, we were happy that 99.4 percent were pretty much straightforward since we automated a lot of the process. The MCC or CC list conflicts can occur when an ICD-10 code would translate into two ICD-9-CM codes – with one on the MCC list and the other one on the CC list – or it might not be considered as a CC at all. So, for the most part, we again used the MEDPAR frequency data but we also used clinical review to resolve all the conflicts.

Slide 34 just gives you an idea of the numbers. In the MCC list, right now we have 1,592 codes and these are replaced by 3,152 codes for ICD-10. On the CC list we currently have 3,427 codes and those are replaced by 13,594 codes for ICD-10.

To give you an example of the straightforward translations, we have a couple of the heart failure where you have the acute systolic failure in ICD-9 and its replacement for ICD-10. These went without any problems.

On slide 36, we have an example of one of those list conflicts where for ICD-10 code R78.81, Bacteremia, it includes the concept of septicemia. When you translate that to ICD-9, you have two codes – one code for the unspecified septicemia and another code for the bacteremia. Both of these conditions are assigned to different lists for the MCC or CC categories. So you can see to resolve that conflict that the bacteremia was assigned to the MCC list because of the higher frequency data.

On slide 37, we talk a little bit more about the cardiovascular MS-DRGs. And, for the most part, the conversion went smoothly but we did find some challenges in a couple of areas that we'll discuss in the next couple of slides.

On slide 38, we have an example for the coronary artery bypass MS-DRGs where we had nine ICD-9-CM codes that were replaced by 232 ICD-10-PCS codes without any problems. And although the number might look large, you want to keep in mind that the ICD-10-PCS codes specify the number of coronary arteries that were bypassed, the specific artery being bypassed, the graph material, and the approach. And the example is for 36.11, Aortocoronary bypass of one coronary artery, and that's replaced by eight codes in ICD-10-PCS. The numbers in the brackets provide all the valid possibilities for that specific character.

On slide 39, we have another issue that involved the cardiovascular section and it has to with the coronary atherosclerosis codes specifying angina. There's eight ICD-10-CM codes that are considered combination codes – where they specify both the underlying diagnosis of the atherosclerosis and the current exacerbation of unstable angina. So when it's coded as a principal diagnosis, the logic is modified to assign the coronary atherosclerosis combination code to the appropriate "with MCC or CC" MS-DRG, even when there aren't any secondary diagnoses recorded.

There is an example on slide 40, just to give you an illustration. The ICD-10 code for the combination translates to two codes in ICD-9-CM so you'll see that when the ICD-10 code is the principal, the logic will be modified.

Another area in the cardiovascular MS-DRGs is shown on slide 41, where there's differences with the myocardial infarction or MI codes. Currently in ICD-9-CM, we have information in those codes that talks about the patient encounter. So we have initial episode of care as well as subsequent and unspecified episodes of care. The initial episode of

care goes to one set of DRGs while the subsequent and unspecified episodes of care go to different DRGs.

On slide 42, we talk about how these issues were resolved. Because in ICD-10-CM, the information about the encounter has been removed – those cases that would specify the subsequent or unspecified encounter – they're not replicated in ICD-10. The frequency data for those types of codes was low and we expected those to have minimal impact. And there's an example on the next couple of slides.

Starting at slide 43, you see for MS-DRGs 280 to 285 for the Myocardial infarction, for code 410.71, the Subendocardial infarction for the initial episode of care – there were over 500,000 MEDPAR records. This code is replaced by the single I21.4 ICD-10 code.

On slide 44, we see examples where these concepts were not replicated in ICD-10 based MS-DRGs. The frequency data was low. You can see that it was 1,118 for the episode of care unspecified and 16,000 for the subsequent episode of care, so those are comparatively low compared to the previous slide.

On slide 45, we talk about some of the clusters. There were a few areas where we needed to have these clusters to fully replicate the assignment logic.

So slide 46 gives you an example of the cardiac defibrillator MS-DRGs. If you look in the left-hand column, you'll see that two ICD-10-PCS codes are required to replicate the MS-DRGs 222 through 227 where the current logic only looks for one ICD-9-CM code. And you can see the next two rows – they have one code from the first group going to a different DRG and then the other code going to another code in ICD-9 with another set of DRGs. So these were three mutually exclusive categories.

On slide 47, we start to talk about the musculoskeletal system. And, again, the conversion for these went pretty well. There were a few

areas that provided challenges and we'll talk about those in the next couple of slides as well.

On slide 48, MS-DRGs 533 and 534 describe Fractures of femur. We had 14 ICD-9-CM codes replaced by 273 ICD-10-CM codes without any problems. And, remember, these codes specify laterality – meaning the right side or the left side – as well as the anatomic site and the type of fracture. So the example shown is – we have 821.01 for Fracture of shaft of femur, closed, replaced by the S723**A Fracture of shafted femur, initial encounter for closed fracture, in ICD-10. That comes out to 36 codes and the asterisks in the example means that all valid possibilities for codes in that category or the subcategory are included.

Another challenging issue was replicating the wound debridements. For ICD-10-PCS, the codes do not contain diagnosis information like some of the ICD-9-CM codes do now. So the logic differentiates between procedure codes for excisional wound debridement, which fall into MS-DRGs 463 through 465 and the other codes for the excision of soft tissue which group to MS-DRGs 500 to 502.

So on slide 50, we just let you know that the frequency data for the wound debridement procedure is overwhelmingly dominant compared to the procedure codes for excision of soft tissue, so the result was the ICD-10-PCS codes for excision of soft tissue were assigned to MS-DRGs 463 to 465.

Slide 51 just illustrates an example. We have the ICD-10 code and it's assigned to the MS-DRGs for wound debridements. And this decision was, again, supported by the frequency data.

And another example on slide 52, where we have the ICD-10 code for Excision of right lower leg subcutaneous tissue and fascia, open approach. And that, again, is assigned to DRGs 463 to 465.

The other area in the musculoskeletal system that presented a little difficulty were the hip and knee revisions where, again, we had to write programs to find the clusters to fully replicate the MS-DRG assignment logic.

So similar to the previous example, you see on slide 54 we have two ICD-10 codes that are needed to replace the one ICD-9 code to fully replicate that DRG logic to assign it to 466 through 468.

On slide 55, we start to talk about the steps that you would need to take for converting similar projects. The first thing you want to do is find the list of the ICD-9 codes in an application. The second thing you want to do is use those ICD-10 and PCS codes to the ICD-9-CM GEMs in reverse lookup to find the translation of each ICD-9 code on a list. You remember Pat discussed using the GEMs. And those are on our website. And we'll give you the resources again a little bit later.

On slide 56, step 3 – you want to use the translations that you found in the previous steps and replace those lists with the ICD-10 list. Any list conflicts that you encounter, you want to resolve. And, again, you want to look for the instances where you have two ICD-10 codes going to one ICD-9 code and there's different DRGs involved.

On slide 57, again, you want to resolve the list conflicts – choosing which list those codes belongs to. And that also involves the MCC and CC lists that we discussed earlier. In step 6, you want to identify those general ICD-9 procedure codes. And Pat had discussed an example of that with code 92.27. You want to make sure that it is assigned to the appropriate anatomic site or body system MDC. You also want to identify those clusters that we just gave examples of to fully replicate the logic and make sure they get assigned to the right payment group.

On slide 58, number 8 – you want to perform a final review of those translated lists that you have to discover any additional issues that you might come across. For example, we talked about the combination codes with the atherosclerosis and angina. You want to make sure

that they're being assigned to the appropriate MS-DRG. And, lastly, you want to make sure that you create the ICD-10 based copy of the application by replacing all the ICD-9 lists with the final translated ICD-10-CM/PCS lists. And I'll turn it over to Pat to go over the resources.

Pat Brooks: Thanks, Mady. The one resource we've already mentioned on slide 59 that's important is the MS-DRG conversion report. And we give the website for that. And at that website you'll find a number of very useful things. You can even find links there for the full Definitions Manual for the ICD-10 based MS-DRGs. You can look at that and find all the information about how we went about doing the project and what we suggest for you if you're doing a similar project. One other thing that I didn't mention earlier that I'd like to mention now is that if you have a very small number of codes to convert or maybe one code, you may not want to go through all that we've talked about today using the GEMs. It might be quicker for you to simply pick up an ICD-10 code book and code directly whatever the condition or procedure you're trying to code. So it may not be that complicated if you're looking at one or a small list of codes. Going to the second piece of information on our resource slide, on page 59 we have a general ICD-10 website. For those of you who have not looked at that, I would urge you to do so. And you'll find that we have the complete ICD-10-CM – the complete coding system – with the diagnosis codes tabular and the indexed posted on our website. In addition, we have the complete ICD-10-PCS procedure coding system – the tabular and the indexing – posted on our website. By the end of December, we will update all these files with the 2010 version of both coding systems. The ICD-10 also has the General Equivalence Mapping so it's mappings between ICD-9 and ICD-10. For those of you who want more detail about how to use the GEMs, you can listen to the prior outreach calls. You can also look for a User Manual that gives you detailed instructions on how you can use the GEMs yourself. So, there are fact sheets on the General Equivalence Mappings. And then we have – our – the sponsored calls, the education resources, and sponsored calls. One new resource we've posted on our resources list is that for HIMSS, the

Health Information and Management System Society. HIMSS has agreed to serve as a resource for those of you who are looking for possibly vendor application software, whatever. They've agreed, if vendors contact them, to provide a list of what's available. We frequently get the questions on these calls about who's doing what and what's available. And CMS really isn't in the business of keeping up with all of that, but we're very pleased that HIMSS has agreed to. So you want to watch that website if you have questions in the future about what vendors are doing. And that's pretty much it for me, Ann.

Ann Palmer: Thank you. We will now answer any additional questions participants may have. Again, please note that specific coding questions are outside the scope of this call. Amanda, could we please open the phone lines?

Operator: As a reminder, to ask a question press star followed by number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question and please pick up your handset before asking a question to assure clarity. Please note your line will remain open during the time you're asking a question so anything you say or any background noise will be heard into the conference. Your first question comes from the line of Laura Staeger. Your line is open.

Laura Staeger: Hi, I am Laura Staeger. I work at Virginia Mason Medical Center in Seattle. And one of the concerns we have is – we have no intention of double coding. In other words, both ICD-9, ICD-10 in either our coding system or our billing system but we are concerned that some payers may not be ready to pay based on ICD-10. So is it going to be the responsibility of the provider to translate for that payer or is the payer going to be responsible for translating before they make payment?

Pat Brooks: Well, let me just tell you that it is a HIPAA requirement, not a CMS requirement, but a HIPAA requirement that all payers/providers – when you're doing your electronic billing beginning October 1, 2013 – you must accept ICD-10 codes. So if a payer receives it, the payer cannot

require you to continue double coding with ICD-9. Now it may be that if some payers have not gotten around to converting their payment systems, such as we at CMS are now doing, then what'll probably happen for them is they'll receive your ICD-10 codes and then they would have to convert them back into their own payment logic. We're urging them not to do that. That's why we're having tools available well in advance – providing them to all the payer communities so they can begin their own internal translation and work on their systems. And our – and CMS has a group, OESS, that's leading the agency for ICD-10 – meeting with outside groups, trying to make sure that people are working together to facilitate moving forward, to getting ready to implement ICD-10. So, I would tell you that it is required by HIPAA that they take your ICD-10 codes beginning on that date and …

Laura Staeger: Yes, the thing we're concerned about is if they're not ready, they will just hold claims until they are. And would it behoove us to be able to translate for them in that case. Or if they are not ready, is there going to be a fine which would force them to be ready?

Pat Brooks: You know, I cannot get into those type fines because I don't work in that office but it's an issue that I'll raise with our group that's leading that effort. And perhaps they can work on a frequently asked question or try to do something to work to let other payers know about moving forward and being ready. But thank you for …

Laura Staeger: Okay, thank you.

Pat Brooks: … placing that concern.

Laura Staeger: Thank you.

Operator: Your next question comes from Nat Paliop. Your line is open.

Nat Paliop: Good afternoon. This is Nat Paliop and I'm the Business Office Director at Gilbert Hospital. I was – because, you know, the person who went through the website address went through it so fast it was

hard for us to keep track of that address and follow you. Is there a chance you could mail the transcripts to us, if we request?

Pat Brooks: What we're going to be doing – and do you have the slides that we posted on our website for these calls?

Nat Paliop: Yes.

Pat Brooks: Okay, we provide all the websites on slide 59 and others, but in addition what we planned to do. And I'm sorry if we talked too fast. We will be providing written and oral transcripts that we'll post on the CMS website in the area on slide 59 that says "ICD-10 Sponsored Calls." If you'll watch that over the next few weeks, up to a month. I'm not sure how long it'll take them to type all this up but once they've typed up the full meeting today, then you can just go there and download a written transcript of everything we've said.

Nat Paliop: Would you repeat the website address for me?

Pat Brooks: Yes, it's rather long but if you want the Sponsored. Let me give you the ICD-10 website. This may be better. If you go to www.cms.hhs.gov/ICD10 – when you get there, look on the left side of the page where you'll see the 2009 Sponsored Calls and click there.

Nat Paliop: Okay and that should take me to the link?

Pat Brooks: That will take you to the links and within the next few weeks you'll see a complete transcript of this call today. If you have questions about the General Equivalent Mappings, which we didn't go into much detail today – that wasn't the purpose of this call – but you can see the call that we had previously on that. The full transcripts are posted, the slides used – so you can listen to the previous one and maybe get a little better background about what the mappings are all about.

Nat Paliop: Sounds good. Thank you very much.

Pat Brooks: You're welcome.

Operator: Your next question comes from Kay Dimmitt. Your line is open. I apologize. Your next question comes from James Kennedy. Your line is open.

James Kennedy: Thank you very much. This is James Kennedy – Dr. Jim Kennedy. I'm with FTI Healthcare in Atlanta. The first question I have is that there are some changes in ICD-9 that are different from – I mean – ICD-10 from ICD-9 such as hypertension no longer is split up into accelerated or malignant hypertension, you know, like we have in ICD-9. It goes to – all the hypertensions go into the I-10 code and the code is I-10. My question is will there still be an evolution of ICD-10 over the next two or three years prior to its implementation on October 2013? And how does one participate or provide comments for that?

Pat Brooks: That's an excellent question and we've covered that in some of our earlier calls. And let me provide it for the audience today. We meet twice a year with the ICD-9-CM Coordination and Maintenance Committee. That Committee discusses updates to ICD-9, and it also discusses updates to ICD-10. Based on some discussions we've had this year where we've updated the 9 codes and people have requested updates to the 10, we will be doing a 2010 update to both ICD-9 and ICD-10. We will continue to do updates prior to implementation. One very important outstanding issue that we have not decided about yet that was discussed at the September 2009 Coordination and Maintenance Committee and that issue is as follows: Some people ask us in that ICD-10 Final Rule – you can read through that – they ask us to freeze the updates to ICD-10 and/or ICD-9 prior to the implementation of ICD-10. Those particular people felt like that annual updates, up through implementation, made it more difficult for them to convert payment systems, to develop books – ICD-10 books – training manuals, to do edits, and to update systems. And those people urged us to have what we will refer to as a "freeze." We discussed that generic issue at the September meeting. People had views – a variety of views. Some people thought that it was a good idea to continue updates through 2010, and then to not update at all. Or just update with a small number of new technology and diagnosis codes up until

ICD-10 is implemented or the year after it's implemented. Other people thought that we ought to continue the updates annually until 2011, others 2012. So we had various people who agreed annual updates with one or both systems or freeze both of them for a couple of years. The issue is so important that we've asked people to send in their written comments on that issue. And you have my website. You can send them to me through the end of the year if you feel like we should aggressively continue updating annually the coding systems. And if we do, that is done at the Coordination and Maintenance Committee. You can come to the meeting or you can read the summary reports of the meeting and send your comments in later – either way you want. We will take all these comments we've received. And in this spring's Inpatient Prospective Payment System Proposed Rule, we will discuss the issue of whether or not we should freeze ICD-9 and/or ICD-10 codes. And the public will be given the opportunity to comment on that through formal rulemaking. After that's resolved and then we have to keep in mind that we do need to have flexibility to create codes for new technologies or new diseases, but perhaps a freeze would be on everything else so that people could have some stability. But we will go through formal rulemaking and it's pretty undetermined now what that exact proposal would be. But we look forward to receiving anybody's suggestion on that issue of freezing the codes or not.

James Kennedy: Thank you. The next question, very briefly, last week the Part B folks had a listening conference on the physician value-based purchasing and the development of an episode grouper in order to measure physician efficiency. Currently there are two commercial groupers, which are off the shelf, which Medicare does not intend to use. These currently use ICD-9 codes and we did have a very interesting discussion about – the – that how this will map to ICD-10. Has there been any communication between the, you might say, the inpatient side of Medicare and the outpatient side of Medicare of how Medicare will use ICD-10 in assessment of physician efficiency as part of the value-based purchasing program?

Pat Brooks: I'd say we've done more than that. We, in CMS, have established an ICD-10 Steering Committee, which the various components are part of. We've started to discuss plans for updating our systems, for converting our payment systems, our edits, and all that. We're discussing how best to go about doing that. The earliest part of that step was that we needed to have these tools, the General Equivalent Mappings, so that the rest of the Agency could use …

James Kennedy: Yes, ma'am.

Pat Brooks: Now that we've got our experience, the rest of the Agency is very well aware that anything that uses an ICD-9 diagnosis code or ICD-9 procedure code, any payment system or edit must be converted. And we are discussing right now how we will go about doing all that work in a timely fashion.

James Kennedy: Thank you. And one final question – many Medicaid patients and some Medicare patients in the nation are paid on the APR-DRG methodology. Is there – and these are funded by the Federal government, you know, like in Maryland or other states that use APR-DRGs. What will be the timeline for the rollout of mapping of ICD-10 to the APR-DRG methodology?

Pat Brooks: You know, I can't really respond to you on that because I don't know what their timeline would be. We are very early on the DRG mapping simply because we undertook this exercise to learn how to do a big conversion. And share it with the rest of the industry. But others are studying that process and will be determining their own conversion and their own rollout times. So I don't think anybody else, including other components within CMS, have announced those firm timelines yet.

James Kennedy: Okay, thank you very much for an excellent call.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Wendell Clark. Your line is open.

Wendell Clark: I am Wendell Clark with Nurses Unlimited Home Health Agency in Odessa, Texas. My calls are concerning the date of inception. You mentioned that ambulatory patients are – would be – October '13 and new hospital patients would be starting at that point, when they get put in the hospital. How that affects home health and where would our dates fall?

Pat Brooks: Home health – if you have a home health service on October 1, 2013 on that day and afterwards, you'll be reporting ICD-10 codes. So it's the date of service for this care.

Wendell Clark: We would have to actually recertify our patients with ICD-10s on October 1 for all active patients at that point?

Pat Brooks: You know, the issue of certification and all that I cannot talk to you about how that will happen. I can only tell you that reporting, in general, and I think different parts of the agency, we have issues that we're discussing internally where they still span a few days over October 1, 2013, CMS is discussing right now how we're going to instruct our providers to deal with that. But, in general, the right answer for you is to begin planning so that on October 1, 2013 – that's the day you switch to ICD-10 coding.

Wendell Clark: Thank you. Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from Michael Rideout. Your line is open. Your next question comes from Laura Dugger. Your line is open.

Pat Brooks: Are there any other questions?

Operator: I apologize. It'll be just one moment. Ladies and gentlemen, this is the operator. I apologize, but there will be a slight delay in today's conference. Please hold and the conference will resume momentarily. Thank you for your patience. This is the conference operator. Your next question comes from Janet Tudor. Your line is open.

Janet Tudor: Thank you, I found what I needed.

Ann Palmer: Okay, thanks.

Operator: There are no further questions at this time.

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

Operator: This concludes today's conference. You may now disconnect.

END