

**Centers for Medicare & Medicaid Services  
ICD-10 Implementation in a 5010 Environment  
Follow-up National Provider Call  
Moderator: Hazeline Roulac  
September 13, 2010  
12:00 p.m. ET**

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Operator: Welcome to the ICD-10 Implementation in a 5010 Environment Follow-up National Provider Conference Call.

All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

Thank you for your participation in today's conference call. I will now turn the conference over to Hazeline Roulac.

Ma'am, you may begin.

### **Welcome**

Hazeline Roulac: Thank you Simon. Hello. I'm Hazeline Roulac from the Provider Communications Group here at CMS. I'd like to welcome you to the follow-up national provider conference call, focused on ICD-10 implementation in a 5010 environment.

Our experts will review basic information about ICD-10 and 5010 and explain how they are interrelated. At the end of the presentation, we will open up the phone line to give you an opportunity to ask questions of our subject matter experts.

Before we get started, there are few items I need to cover. There has been a tremendous amount of interest in this call and we apologize that we were not able to accommodate everyone who tried to register. This call is being transcribed and recorded. Written and audio transcripts will be posted to the CMS Sponsored Calls section of the CMS ICD-10 website in approximately one to two weeks following this conference call.

The website address is [www.cms.gov/icd10](http://www.cms.gov/icd10). There are two handouts for this session, a slide presentation and a special edition MLN Matters Article, SE1019. If you have not already done so, these handouts may be downloaded now from the CMS ICD-10 website located at [www.cms.gov/icd10](http://www.cms.gov/icd10). At the left side of the web page, click on CMS Sponsored Calls. Scroll down the

page to the Downloads section and then please select both the September 13<sup>th</sup>, 2010 ICD-10 Conference Call Slide Presentation and the MLN Matters Article, and the link says SE1019.

And last, please be aware that continuing education credits may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS National Provider Conference Calls.

Please see slides 54 and 55 of the slide presentation for more information. If you have any questions regarding the awarding of credits for this call, please contact your particular organization. We encourage you to retain your presentation materials and confirmation e-mail.

All right, so we have a lot to cover today. So, without further delay, we will get started. At this time, I would like to introduce our three speakers for today who are subject matter experts on ICD-10 and 5010.

We are pleased to have with us Pat Brooks, Senior Technical Adviser in the Center for Medicare Hospital and Ambulatory Policy Group at CMS; Christine Stahlecker, Director of the Division of Medicare Billing Procedures in the Office of Information Services at CMS; and Sue Bowman, Director of Coding Policy and Compliance at the American Health Information Management Association, or AHIMA.

We welcome each of you and thank you for taking the time out of your busy schedules to talk with us today about these very significant changes that will impact the entire health care industry in some way.

And now, it is my pleasure to turn the call over to our first speaker, Pat Brooks from the Center for Medicare at CMS.

### **ICD-10 Implementation**

Pat Brooks: Thank you Hazeline. And, I'll start on slide three with ICD-10 implementation.

October 1<sup>st</sup>, 2013 is the compliance date for implementation of ICD-10-CM, which diagnoses, and ICD-10-PCS for procedures. There will be no delay or no grace period. That is a firm compliance date of October 1<sup>st</sup>, 2013.

Moving on to slide four, ICD-10-CM, the diagnoses will be used by all providers in every health care setting. So, if you now are coding a diagnosis using ICD-9, then you will begin using ICD-10-CM on claims for services provided October 1<sup>st</sup>, 2013.

ICD-10-PCS, the Procedure Coding System, will be used only for hospital claims for inpatient hospital procedures. ICD-10-PCS will not be used on physician claims, even those physician claims that are for inpatient visits. Therefore, for hospitals that code now was ICD-9-CM procedure codes, they will convert to ICD-10-PCS.

Moving on to slide five, CPT and HCPCS, we'll point out there will be no impact on Current Procedural Terminology, CPT, and on Healthcare Common Procedure Coding System, HCPCS codes.

CPT and HCPCS will continue to be used for physician and ambulatory services, including physician visits to inpatients. Therefore, to stress again, ICD-10 will not replace CPT and HCPCS.

On slide six, you'll see that we will have a single implementation date of October 1<sup>st</sup>, 2013 for all users. It will be the date of service for ambulatory and physician reporting. So, ambulatory and physician services provided on or after October 1<sup>st</sup>, 2013, will use ICD-10-CM diagnoses codes. We will use the date of discharge for hospital claims for inpatient settings.

So, for inpatient discharges that occur on or after October 1<sup>st</sup>, 2013 you will use ICD-10-CM for diagnoses and ICD-10-PCS for procedure codes. And once again, that's for hospital claims.

On slide seven, you will see that ICD-9-CM codes will not be accepted for services provided on or after October 1<sup>st</sup>, 2013 and ICD-10 codes will not be accepted for services provided prior to October 1<sup>st</sup>, 2013.

Moving on to slide eight, we will note that ICD-10 is quite different from ICD-9. ICD-10 codes are different from ICD-9 codes in the following way: ICD-10 provides greater detail in describing both diagnoses and procedures. There are also more ICD-10 codes than there are ICD-9-CM codes.

The ICD-10 codes are longer, and they use more alpha characters, and Sue Bowman from AHIMA will be getting into greater details later on ICD-10-CM. System changes are also required to accommodate these longer and different ICD-10 codes, and Chris Stahlecker will be describing those system differences.

Moving on to slide nine, I will point out that we have included a website where you can find the complete versions of ICD-10-CM and ICD-10-PCS. These coding systems are updated annually, and we post the complete systems each this year. You can currently find version 2010 on the web page indicated.

Also, maintenance updates of ICD-9-CM and ICD-10 codes are discussed at the ICD-9 Coordination & Maintenance Committee, which we commonly refer to as the C&M Committee. I've provided the website in the bottom of slide nine where you can find information about C&M meetings and summary of the discussions.

Moving on to slide 10, we've developed tools to help you in converting codes. We developed the General Equivalence Mapping, also called GEM, to assist in converting data from ICD-9-CM to ICD-10. These GEMs have forward and backward mapping.

For complete information about the GEMs and their use, go to the website indicated and then either click on the ICD-10-CM codes for the diagnoses GEM or click on the ICD-10-PCS codes to find the procedure GEM.

In addition, we have a project now where we are converting the ICD-9-CM based MS-DRG to ICD-10 codes. And, we called that our MS-DRG Conversion Project. To learn about our experience in using the GEMs to convert a large and complex system, you can go to this site and learn more.

Slide 11, this is a very important point. The GEMs are a very useful tool in converting data, but they are not a substitute for learning how to code with ICD-10. You will have to learn how to use the new coding system. However, for some small conversion projects, you may not even want to use the GEMs. It may be quicker and more accurate to use ICD-10 code books.

Moving on to slide 12, we will mention a provision in the Affordable Care Act. Section 10109(c) of the ACA requires the Secretary of Health and Human Services to task the ICD-9-CM Coordination & Maintenance Committee to obtain input regarding the GEMs and to make any appropriate revisions to the GEMs.

We will be discussing this issue at the meeting this week, September 15<sup>th</sup> and 16<sup>th</sup>, of the ICD-9-CM Coordination and Maintenance Committee. I provided a website with the information about that meeting.

The registration is now closed as we did reach room capacity. However, we will be providing 225 call in numbers for those of you who would like to participate by phone. If that maximum is reached, then we will be providing audio and written transcript of this meeting for you to review later.

On that website, we have put early copies of the agenda and we have also put an updated 2010 version of the GEMs. These are based on comments we've received so far and they will assist in our discussion on the meeting for September the 15<sup>th</sup>. Later this week, these files will be updated to include an updated agenda and all the handouts and the proposals that will be discussed at the September 15<sup>th</sup>'s meeting.

Please check that website tomorrow and the day after. Hopefully, it will be visible at that point.

Moving on to slide 13, we will discuss the possible need for a freeze. An important agenda item for the C&M meeting this week is if there's any need for freezing of codes. Annual code updates make transition planning difficult. Vendors, system maintainers, payers, and educators have requested a code

freeze and the question they ask is, “Should ICD-10-CM and PCS and/or ICD-9-CM be frozen prior to implementation on October 1<sup>st</sup>, 2013?” And if so, when should a freeze begin. We will be discussing that item the morning of September the 15<sup>th</sup>.

Moving on to slide 14, this topic has been discussed at a recent Coordination & Maintenance Committee. So if you want to see the comments received in the past, you can go to the slide. You can also see any handouts on this discussion later this week about the freeze.

Based on prior discussions, a limited freeze is being proposed. Slide 15 describes what is being proposed. It's proposed that the last regular annual update to both ICD-9-CM and ICD-10 would be made on October 1<sup>st</sup>, 2011. Only limited ICD-9-CM and ICD-10 updates for new technologies and new diseases would be made on October 1<sup>st</sup>, 2012 and for ICD-10 on October 1<sup>st</sup>, 2013. Then, we would begin regular updates to ICD-10 beginning on October 1<sup>st</sup>, 2014.

Moving to slide 16, you will see that a final decision on any code freeze will be announced at September 15<sup>th</sup> to 16<sup>th</sup> C&M meeting. At the website, once again – and you can find information on the call in lines provided if you look on that page under the Downloads. If you're not able to listen in to the meeting or attend, then audio and written transcripts will be posted after the meeting.

Moving on to the next slide beginning on 17<sup>th</sup>, we have several resource slides that might be extremely useful to you, beginning with slide 17 where we give you the ICD-10 general information slide, the MS-DRG Conversion Report page that I've mentioned earlier, and also, we've included information where you can get information on 5010.

On slide 18, we give you information where you can find links to other ICD-10 related information. And an important location for our CMS Sponsored Calls, like the one we're having today. Future calls will be listed on the CMS Sponsored Calls page. And, as Hazeline already mentioned, you'll be able to

find written and audio transcript with prior slides that you might extremely useful.

Slide 19 includes some very good resources for providers or Medicare service providers, that you might want to review after the meeting. Feel free to print out these slides and you can train people in your own institution about ICD-10.

On slide 20, we mentioned other things that are also included on this slide and I'd urge you to browse the ICD-10 website. You'll find information on ICD-10 and 5010 compliance timeline, implementation planning, Medicaid payer and vendor resources, statutes and regulations, the C&M meetings, which we've discussed, and the ICD-10 MS-DRG conversion project.

And the last slide I'll be mentioning this morning, slide 21, we have two organizations, WEDI and HIMSS, that offered to post ICD-10 resources. So, any organization, should they want to, can ask these organizations to post resources they provide. And so they're sort of central areas where you could go to look for information that might be useful to you.

And with that, I'll turn the meeting back over to Hazeline.

Hazeline Roulac: Thank you Pat.

Our next speaker is Sue Bowman, Director of Coding Policy and Compliance at AHIMA. She will be speaking with us today in her role as one of the ICD-9-CM cooperating parties. A cooperating party represents a longstanding public and private sector partnership between AHIMA, CMS, The American Hospital Association, and The Centers for Disease Control and Prevention.

Please note that CMS does not endorse outside organizations, materials, or activities. Sue will start on slide 22 and may also refer us to the MLN Matters Article.

I'll now turn the call over to Sue.



## ICD-10 Code Structure & Examples

Sue Bowman: Thank you Hazeline.

And my role today is I'm going to cover very briefly an overview of ICD-10-CM and 10-PCS. But before I get started, I was asked to mention that if you have an AHIMA credential in which to claim CEUs for today's program, today's 90 minute program is worth one CEU.

Simply report the CEU for this program as part of your AHIMA CEU reporting cycle and maintain documentation about today's program, such as the slide presentation in case of an audit.

For additional information about AHIMA CEU requirements, you can find a PDF copy of the Recertification Guide on the AHIMA website. For those of you who may be credentialed by other organizations and you're not sure of the CEU reporting requirements for that organization, I recommend that you would contact that organization for further information about reporting CEUs.

Now, we're going to go ahead on slide 23 and look at a comparison of the structure between ICD-9-CM and ICD-10-CM codes. As I'm sure you're all aware, the ICD-9-CM diagnoses codes have three to five characters. The first character is numeric or alpha, with the alpha being limited just to the E or V codes. Characters two through five are always numeric. There's always at least three characters to a code, and there's a use of decimal after three characters.

The ICD-10-CM codes have three to seven characters. The character one is alpha. All letters except the letter U are used. Character two is numeric. Characters three through seven are alpha or numeric. There is the use of a decimal after three characters. The system uses a dummy placeholder x, which I'll be talking a little bit more about later, and alpha characters are not case sensitive, meaning that lower and upper case letters aren't used to mean different things in the coding system.

ICD-10-CM has many similarities to ICD-9-CM; for example, it has a tabular list and index that are structured very similarly to ICD-9-CM. The chapters in

the tabular lists are quite – are structured quite similarly, with a few minor exceptions. For example, a few chapters in ICD-10-CM have been restructured in sense organs, meaning the eye and ear conditions have been separated from the nervous system chapter and moved to their own chapters.

Just as in ICD-9-CM, the index is divided into the Index to Diseases and Injuries and the Index to External Causes. The alphabetic index lists the main terms in alphabetical order with indented sub-terms under the main terms, just like it does in ICD-9-CM. And, we'll look at a couple of examples a little bit later. And, just like in ICD-9-CM, there is a Table of Neoplasms and a Table of Drugs and Chemicals.

Many conventions have the same meaning in both ICD-10-CM and ICD-9-CM. And, what I mean by conventions are things like abbreviations, punctuations, symbols, and instructional notes such as “code first” or “use additional code”. There are still non-specific codes known as unspecified or not otherwise specified in the code descriptions that are available to use if when there is not sufficient detailed documentations to support a more specific code assignment.

Slide 26, just as in ICD-9-CM, we still have a set of Official Guidelines for Coding and Reporting that accompany and complement the ICD-10-CM conventions and instructions. And just as with ICD-9-CM, adherence to the official coding guidelines in all healthcare settings is required under HIPAA.

Now, some of the differences in ICD-10-CM from ICD-9-CM; well, one is that laterality, meaning the side of the body affected, has been added to appropriate chapters including the eye, ear, neoplasm, and injury chapters. Basically, those conditions that have left or right components to those organs.

This feature allows you to classify the right or left side as well as bilateral. Today, this information is often readily available in the medical record. But because ICD-9-CM doesn't capture this information, we're not collecting it through the ICD-9-CM codes. In ICD-10-CM, if the affected side of the body is not documented, there are still codes to indicate unspecified side.

The level of specificity and detail has been greatly expanded in ICD-10-CM, and that's probably the area of difference that most people are familiar with. And that is the biggest area of differences, is the level of specificity. Some of the areas where there's significant expansion include the injury chapter, diabetic conditions, post-operative complications, and alcohol and substance abuse.

One of the really great new features of ICD-10-CM is the expansion of many more combination codes for conditions and their associated common symptoms or manifestations. This allows one code to be assigned rather than multiple codes, and provides a clear linkage between the underlying condition and the associated symptom and manifestation.

It also facilitates the coding process when it's often very difficult to determine an ICD-9-CM when there's two closely related conditions, which one really is the best principal diagnosis. And these combination codes eliminate the need to have to worry about that, by putting information into a single code.

Also, in ICD-10-CM, injuries are grouped by body part rather than by categories of injury. So, all injuries of a specific site, like head and neck for example, are grouped together rather than the type of injuries, such as all fractures or all open wounds being grouped together.

On slide 28, some additional differences in ICD-10-CM are clinical concepts that are not currently in ICD-9-CM but have been added. And examples of those are underdosing, blood type, and Glasgow Coma Scale.

Another difference is that the obstetric codes identify the trimester rather than the episode of care. The episode of care meaning that in ICD-9-CM, currently you assign a fifth digit to identify whether the patient has delivered or not and whether the condition is antepartum or postpartum. And that distinction is not present in ICD-10-CM. Instead, the OB codes identify the trimester, which is believed to be more clinically significant for identifying those conditions.

Definitions of some codes have changed to keep up with advances in modern medicine. For example, the timeframe that a myocardial infarction is considered acute is now four weeks instead of eight weeks.

And, as I mentioned earlier in some chapters, some categories have been restructured, some codes have been reorganized. And, one of the major benefits of a lot of these changes in ICD-10-CM is that the codes reflect modern medicine and more updated medical terminology.

One of the key differences in ICD-10-CM is the addition of a seventh character, which is used in certain chapters to provide additional information about the encounter. Some key factors about the seventh character are that it must always be used in the seventh character position, and if a code has an applicable seventh character, the code must be reported with an appropriate seventh character value in order to be valid.

Some examples of how the seventh character is used is that, for injuries, it identifies whether it's the initial encounter for that injury, a subsequent encounter, or a sequela of that condition. In the obstetrics chapter, the seventh character identifies the fetus for which the code applies in cases of a multiple gestation.

On slide 30, as I have mentioned earlier, there is the addition of a dummy placeholder, x, used in certain codes, and it's used as a fifth character placeholder to allow for future expansion in some codes, and it's also used to fill in empty characters when a code that is less than six characters in length requires a seventh character.

Remember, I just mentioned that the seventh character always has to appear in the seventh character position, so this placeholder x is used if a code less than six characters in length needs to have a seventh character appended.

When the placeholder character applies, it must be used in order for the code to be considered valid. An example of an area where it's used as a placeholder to allow for future expansion is in the poisoning codes where there's obviously a lot of new drugs developing all the time.

Another key feature, which is a tremendous benefit in ICD-10-CM, is that there are two different types of excludes notes. Many of you who are involved in coding at all know that ICD-9-CM can use an excludes note in different ways with multiple meanings, which can be confusing as to what it means.

In ICD-10-CM, this has solved that problem by having an Excludes1 note and an Excludes2 note, which will hopefully clear up all of that confusion. So, for example, an Excludes1 note indicates that the code identified in the note and the code where the note appears cannot be reported together because the two conditions cannot occur together. And, an example is the Excludes1 note under the diabetes code indicating that you have to identify what kind of diabetes the patient has and not use multiple different types of diabetes codes together.

The second type of excludes note is an Excludes2 note, which indicates that the condition identified in the note is not part of the condition represented by the code where the note appears. So, both codes may be reported together if the patient has both conditions. And an example is the Excludes2 notes under the pressure ulcer codes. It's possible to have multiple different types of ulcers, pressure ulcers, diabetic ulcers, varicose ulcers, and so forth. So, this note tells you that if the patient has both conditions, then it's OK to use the two codes together.

In ICD-9, these two types of excludes notes are lumped together into a single excludes note and so it's not always easy to tell whether the conditions are allowed to be reported together or not.

So, we'll just look at the couple of examples here showing how the process of coding in ICD-10-CM really hasn't changed. So, with this example on slide 33 of Type 1 diabetes with diabetic nephropathy, you would first look up the term in the alphabetic index, the main term of diabetes, and then look at the indented sub-term underneath of Type 1 with nephropathy.

And then, step two on the next slide, which shows that you would look the code up in the tabular to verify that you have the appropriate code. So, you can see that the code numbers are different; the specificity in the code description is different. And as an example on these diabetes codes, it groups the main diabetes condition with the manifestation into a single code instead of having to code them separately as we have to with ICD-9-CM. But the process of actually assigning the appropriate code is still pretty much the same in ICD-10-CM as it was in ICD-9-CM.

So, now just very briefly, we're going to touch on the structural differences with ICD-10-PCS. So, as we know with the ICD-9-CM procedure codes, they have three to four characters. All the characters are numeric. All the codes have at least three characters. The alpha characters are not case sensitive, and there's a decimal after the second character.

ICD-10-PCS is quite a bit different. It has a seven character alpha numeric code structure. Any character can be alpha or numeric. The 10 digits, zero through nine, and the 24 letters listed there are used and can be used in any character position. The letters I and O are not used in ICD-10-PCS in order to not be confused with the digits one and zero, and the alpha characters are not case sensitive. And a key significance is, unlike in ICD-9-CM where the codes can be variable in length, every ICD-10-PCS code must have seven characters.

And here is an example of what a code looks like, and the way you assign a code is a little bit different than an ICD-9-CM. It's sort of like a building block approach with each character. So, for example, in this code here, which looks very different than what we're used to today, where a trigeminal to facial nerve transfer percutaneous endoscopic, you can break it down into the characters showing that the first character indicates that it's the med/surg section. The next character indicates that this is the central nervous system. Then you have the root operation, which in this case is a transfer. Then you identify the body part of trigeminal nerve. Then, the next character identifies the approach, which in this case is percutaneous endoscopic. The sixth character is a device character. No device applies to this, so Z is used to

indicate that there's no device. And then the qualifier, the seventh character, identifies some additional information that's not captured by the rest of the code – and in this case it's the other nerve involved in the transfer procedure which would be the facial nerve. So that just gives you a little nutshell of how ICD-10-CM and ICD-10-PCS looks.

On slide 37, it just listed a few of the resources that AHIMA offers. This is obviously just a sampling. There's a lot more information on our website. Many of our resources are free, as indicated there. And in addition to this list, we're also publishing two new books this year on using the GEMs and also a book on using ICD-10-PCS root operations.

And now I will turn it back over to Hazeline.

Hazeline Roulac: Thank you very much, Sue. The next portion of our presentation is on 5010. That starts on slide 38. I will now turn the call over to Christine Stahlecker, from the Office of Information Services at CMS.

### **Implementation of HIPAA 5010 and D.0**

Christine Stahlecker: Well, thank you, Hazeline. And let me also welcome everyone to today's program. That's been a fascinating description of the ICD-10 project and I learned a lot about the ICD-10 codes.

This section of today's presentation is speaking about the new formats that are required to be implemented as a prerequisite before you can even get to use the ICD-10 codes.

This part of our presentation is to let everyone know that today's standard formats for billing claims electronically do not permit the use of ICD-10 codes. So, we need to have this major implementation of our HIPAA EDI format away from the 4010 version and on to 5010, and the NCPDP format from the 5.1 version to be D.0, all completed before we can begin to start to use the ICD-10 code set.

So, I'm going to move right into slide 39 and just to let you know that this section of the program is a review of the compliance dates and timelines for 5010. I'm going to speak a little bit about high level requirements for 5010

and the Medicare Fee-For-Service implementation, and then some tips and just thoughts about how you may be addressing your work efforts for readiness for the HIPAA 5010 and D.0 format, some suggestions about what you could be doing now in order to get ready, and give you a little bit of insight about where Medicare Fee-For-Service stands against their project plan, and share some insights that we have encountered as Medicare Fee-For-Service has been working on 5010 and D.0 update.

On slide 40 is a general overview of what 5010 is all about, what was adapted under the HIPAA Modifications Rule. And, again, these are the Electronic Data Interchange standard and code set under – that are defined under HIPAA. The current version of HIPAA is 4010 and 4010A1. The Modification Rule adopted 5010 of the X12 standards, the whole suite of administrative transactions. We'll speak more about which of the transactions are included, as well as the version D.0 of the National Council for Prescription Drug Program. And within Medicare, the NCPDP format is used for Durable Medical Equipment billing.

And so who is impacted? All HIPAA covered entities. These covered entities were specified by the original version of HIPAA. It includes providers, health plans and clearinghouses. And then there was a security upgrade – update to the HIPAA rule, and that expanded the role of a business associate to also be included as a covered entity, needed to comply with the same requirements as the covered entities. So HIPAA now includes providers, health plans, clearinghouses, and business associates.

On slide 41, within the Medicare Fee-For-Service program, Medicare has updated its format for electronic claims and related transactions. We have called this a program, not just a project, because it does affect our entire Medicare paper systems suite of programs from the Medicare Administrative Contractors that exchange transactions all the way through our systems to national claims history where researchers may be obtaining data in order to forecast trends. So, the entire suite of systems has been affected by this change.



Within Medicare, we've treated this as an infrastructure in preparation for ICD-10. So, 5010 will accommodate the ICD-10-CM and PCS code sets, and 4010A1 does not permit them to be exchanged. Along the way of doing this expansion, as you've heard about the size of the fields being expanded, Medicare has also taken this as an opportunity to increase the number of diagnosis codes and procedure codes permitted in the claim. So, on the institutional claim, we'll be processing up to 25 diagnosis codes and 25 procedure codes per electronic claim.

Part of the Medicare Fee-For-Service implementation includes an enhancement where Medicare is going to be using standardized acknowledgement and rejection transactions. So the Functional Acknowledgement 999 is going to be replacing the 997 transaction, and the 277 Claims Acknowledgement transaction will be used to replace all proprietary error reporting.

So, the current error report format that you may get back from a Medicare Administrative Contractor, a Fiscal Intermediary, or carrier will no longer be in use. Once you've switched over to 5010 format, you'll be receiving a 277 Claims Acknowledgement transaction.

Several other system improvements and process enhancement have also been incorporated as Medicare has implemented the new suite of transactions. On slide 42, we'll see the overall timeline. This was specified in the regulation. The mandatory compliance dates for the new formats is January 1<sup>st</sup> of 2012, well in advance of the timeline for ICD-10 code sets.

Internal testing was to begin on January 1<sup>st</sup>, 2010, and the Medicare Fee-For-Service has met that date. We've had a significant activity in the calendar year of 2010 and are well into internal testing. External testing is scheduled to begin on January 1<sup>st</sup>, 2011. And you'll see the timeline specified at the bottom of slide 42.

Medicare Fee-For-Service has actually started to implement productional components as early as October 1<sup>st</sup> of 2008. So, this has been a big project for

Medicare and it's taken a lot of effort. And we've been implementing components over the quarters of releases since that October 2008 timeframe.

So, we expect to complete our systems testing in the calendar year of 2010 and begin our transition work in the calendar year of 2011. It's notable that during that calendar year of 2011, either format – 4010A1 or format 5010 – can be submitted and used in production mode. And on January 1<sup>st</sup> of 2011 – I'm sorry, January 1<sup>st</sup> of 2012, the 4010A1 format will no longer be accepted by the Medicare – in the Medicare program. So the transition work needs to be completed no later than January 1<sup>st</sup> of 2012.

I also want to emphasize that if you are using the format of 5010 during the calendar year 2011, it will – although the format permits the use of ICD-10 code set that will not be a valid submission. There will be edits in the front-end systems that will not permit the acceptance of an ICD-10 code value during calendar year 2011. That will only begin on October 1<sup>st</sup> of 2013.

On slide 43, what are the 5010 requirements for implementation? Well, first, you'll be required to test a new format as you submit your current production formats to Medicare Administrative Contractors, Fiscal Intermediaries, to carriers. You're currently billing on the 4010A1 formats. Medicare will be ready to support tests of production on January 1<sup>st</sup> of 2011.

And after the 5010 implementation completes on January 1<sup>st</sup>, 2012, all covered entities are required to submit the 5010 formats for the 837 Institutional claim; Professional claim; Coordination of Benefit claim; Eligibility Inquiry responses, that's the 270/271; Claim Status Inquiry response, the 276/277; and also be required to take acknowledgements and error reporting using the 277 Claims Acknowledgement, the 999, and the TA1 transaction set.

And I wanted to emphasize again that although the 5010 format allows ICD-9 or ICD-10 codes during this transition time, only ICD-9 codes can be permitted to be used. And then after October 1<sup>st</sup>, 2013, all covered entities are required to use ICD-10 codes on professional claims with a date of service, or an institutional claim with a date of discharge of October 1<sup>st</sup>, 2013 or later.

Following that timeframe, October 1<sup>st</sup>, 2013, Medicare Fee-For-Service will continue to process ICD-9 codes for a period of time to allow the claim submissions to run out, to allow the billing cycles to catch up. But please understand that it's that date of service or that date of discharge that will affect whether or not your claim will be accepted or rejected.

On slide 44, we wanted to go over a few tips and techniques for becoming 5010 ready and ask you if you have contacted your system vendors. And, we do suggest a series of questions to find out whether or not your current license from your software vendor includes the regulatory update or will you have to expend additional financial resources to obtain an update.

Please be sure to ask whether or not your update will include the acknowledgement transaction, the 277 Claims Acknowledgement and the 999. These are not HIPAA transactions. So, if your licensing agreement only includes regulatory enhancements, these are not specified as HIPAA transactions. They are proposed or they are considered to be proposed transactions, but they're not adopted under HIPAA yet.

And part of the important information to obtain from your vendor is will they give you a feature in the software to take that 277 Claims Acknowledgement transaction and produce a readable error report for you. Medicare will be delivering a transaction set, but in order for it to be usable by you, it will need to be transitioned and transformed into a readable error report. And, that is something you'll be dependent upon your system vendor to do for you if you don't have your own IT resources to do that development work for you.

In the middle of the slide, it would be very helpful if you inquire when your vendor is planning to upgrade your system so that you can get an understanding of the schedule that- where you fall into your vendor's upgrade. You want to make sure that you'll be transitioned early enough so that your workflow isn't inconvenienced and it's transitioned well before the cutoff so that you get experience using the new format before you're close to the cutoff.

And you should be concerned if your vendor is going to be planning your transition very late in 2011 and try to encourage them to do it sooner. The Medicare Administrative Contractors may not be able to handle a flood of requests to test and certify Trading Partners are ready for production. And, you don't want to be caught having your format – the 4010A1 format – cutoff on January 1<sup>st</sup>, 2012.

The final point on this slide is for you to do an evaluation of your routine operations and begin planning for this transition and training your staff. Some of the data content in the new transactions have different data elements. And so, your staff that are doing data entry into a system to prepare to bill may have different data elements that they'll need to be more careful about doing data entry.

In slide 45, additional points from what you might need to do to prepare and some general resources that you might find useful as you're getting ready. First point is that this time you have to purchase the Implementation Guides. Now, an Implementation Guide was offered for free for 4010, 4010A1, but at this point in time, the government isn't doing that anymore. The government is requiring every Trading Partner to obtain their own copy of Implementation Guides. And that it's also important to note that they're called technical reports and the Technical Report Type 3 that is the equivalent name of an Implementation Guide. And here at the sites where you may go to obtain them for X12 and NCPDP. You may also go to the X12 site to review any kind of technical comments that was made on the transaction code or code sets. And then finally, if you are really finding difficulty using this version, they have some sites where you may request a maintenance effort to be made to the transaction sets.

On slide 46, and again, additional points for what you might want to become engaged in now if you haven't already. It is a learning curve to understand what has changed in the format. The formats, again, to reiterate 4010A1 has been converted to 5010 and NCPDP 5.1 to version D.0. So any system you're using to submit claims or receive remittances, exchange claim status inquiries or receive a response, or to send an eligibility inquiry and receive a response

will need to be looked at to understand if you have software changes or billing process changes. These new versions have different data element requirements in some cases.

A comparison has been done by Medicare Fee-For-Service and the results of these comparisons are posted on our – on CMS website at this link. And, you will need to be making changes to your software that produces and exchanges these new formats. It's important that you've a look at your workload to understand which type of payer represents the bulk of your business processes.

So, if Medicare is an important payer to your practice or to your facility, Medicare may be one of your early Trading Partners, one of the early health plans that you want to make sure you test with. However, if you're a pediatric practice, for example, in Medicare it wouldn't be a high importance to you, you may find a different commercial payer to be more practical for you to begin testing with.

So, you'll need to leverage – I just wanted to emphasize that this regulation applies to every single payer there is, not just the government programs— Medicare, Medicaid—it's all the commercial payers, too. So, you'll have to balance who you transition your claim billing formats to first, unless you're making use of a clearinghouse that does that transitional work for you.

On to slide 47, there are some educational materials on the Medicare Fee-For-Service 5010 website, and you'll continue to receive outreach from Medicare regarding program upgrades, technical assistance, and direction for Trading Partners and providers. We have listed here a number of the links and the type of products and informational materials that are available to you. The past audiocasts are available for download and replay.

And onto slide 48, we have a list of the types of audiocasts that have been conducted and are planned yet to be conducted. I will let you know now that between October and December, we're going to be adding a session, an audiocast session, for Coordination of Benefit claims. And so ,that will be in the mid-November timeframe and more information to come on that. And,

here's the link where you can obtain the presentation materials, transcripts, and recordings of all the previous audiocasts.

On slide 49, I wanted to share with you that Medicare Fee-For-Service, as part of its implementation plan, is to require that each of the Medicare Administrative Contractors undergo a certification test with Medicare and that's scheduled to begin in October and complete by December of 2010.

This is- Medicare Fee-For-Service wants to make sure that all of the Medicare Administrative Contractors have implemented their changes for these transactions. That's according to the Medicare requirements. So, a canned set of transactions with predicted outcomes, the accepted transactions or the particular error transactions with specific error code values in those transactions will all be part of the certification test that the MAC, the Medicare Administrative Contractor, will undergo.

If providers are interested in testing your 5010 transactions early or prior to January 1<sup>st</sup>, please contact your MAC. They may be able to support your early interest in testing. Oh, I also wanted to make mention that Fiscal Intermediaries and carriers will also be accommodating this same transition schedule through the calendar year of 2011.

Medicare- even if a Medicare Administrative Contractor is not fully in place in the geographical area and so - what I'm saying is the jurisdictions that across the country that have been specified to be given to a MAC Contractor but that transition has not yet occurred, so you do have a Fiscal Intermediary still processing your claims or a carrier processing your claims. Medicare wants you to know that you may begin to test and transition your 5010 formats on the same timeline. You don't need to wait for MAC to be operational in your area. We have arranged for that legacy contractor, that FI or carrier, to have a partner MAC that is 5010 capable to process that workload. So you may begin your transition work at the same time as those providers in geographic areas that do have a MAC.

On slide 50, I did want to make mention of the errata. There have been some identified situations in the standard transactions that will cause some errata

version to be implemented. Now, there are two types of errata according to the Standards Development Organization. There's a Type 1 and that means that there is a significant change made to the transaction set and that will change the version number that that transaction that is referenced by. And we have an example here, it's going to be identified in a couple locations in the transaction. One location is in the GS08 data element, and we have an example here of 5010X222E2, to mean it's the errata number two for that transaction set. There's another type of errata, a Type 2. It just means that there's a typographical mistake made in the Implementation Guide or the TR3.

Because there are technical errata made already in the 834 or Enrollment transaction, which does not pertain to Medicare Fee-For-Service, but the 835 which is the Remittance, the 837I Institutional claim, the P, the Professional claim, Eligibility Inquiry Response 270/271 and the 999 transaction, Medicare will be implementing the errata transaction set. So, we encourage you to pay attention to the audiocast materials that have been already presented for the 837I & P and 270/271. We will have an upcoming transaction audiocast on the 277 Claims Acknowledgement, and we'll get into more detail in how Medicare will be accommodating the errata.

On slide 51, we did want to let all know that CMS had looked very stringently at the errata and made comments during the open comment period that the Standards Development Organization conducted and we did submit comments to ASC X12 on the errata. Medicare believes that there is minimal impact to the Medicare Fee-For-Service program. CMS will address the errata as a maintenance item as a Shared System maintenance work request and that will be conducted through our Change Request process.

It's important to know and make folks realize that Change Requests have significant lead time. So, within Medicare Fee-For-Service, we need about eight months in advance of scheduling a maintenance item into production. So, the earliest that Medicare believes it could accommodate the errata would be the April quarterly release of its Shared System and that is dependent upon when the errata is officially published as an errata item by the Office of Electronics Standards and Services, OESS.

Although, we mentioned in this final bullet here, an Interim Final Rule, I really would like to line that out. We really do not have a notion yet of how OESS will make it known that the industry will be using the errata transactions or how or when or how we're going to get on to the errata transactions from an industry perspective. I'm sharing with you what Medicare is planning. So, when OESS publishes this, errata directions for the entire industry, Medicare Fee-For-Service will have another look at that and make sure that its plans do accommodate that. So, we are expecting soon an indication from OESS about the errata version of the transactions.

On slide 52, what happens if providers are not ready for transition? Well, providers that are not ready to submit transactions on January 1<sup>st</sup>, 2011 will be able to continue to submit the 4010A1 version or the 5010 – I'm sorry, or the 5.1 NCPDP version of the transaction throughout calendar year 2011. However, January 1<sup>st</sup>, 2012 providers who are not ready to submit the new format by that date will expect to have their transactions rejected. As of January 1<sup>st</sup>, 2012 Medicare Fee-For-Service will only accept claims in versions 5010 or D.O.

There are some providers who are eligible to submit paper claims. This is the providers that have a very low number of employees. So, those providers that do continue to submit paper claims will not experience a change in that paper claim format caused by 5010 or ICD-10 projects.

I think that's about the extent of the information that Medicare Fee-For-Service had available for sharing at today's call so I'll return the audience to Hazeline.

### **Question and Answer Session**

Hazeline Roulac: Great, thank you so much Christine. We've received a lot of good information from our speakers. We've completed the presentation portion of our call and now we're going – we're going to the question and answer session.

But before we begin the Q&A session, I want to remind everyone that this call is being recorded and transcribed, so it's very important that before you ask



your question that you identify yourself with your first and last name and also the organization that you're with.

And, so that we can get to as many question as possible within the next half an hour, we ask that you do limit your questions to just one and as well with our speakers, when you respond to the question, if you would please identify yourself for the benefit of our transcriptionist, that would be appreciated. So, at this time Simon, you may go ahead and open some lines for questions.

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 touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. One moment please for your first question.

Your first question comes from the line of Danielle Jones. Your line is open.

Hazeline Roulac: Hello, Danielle?

Operator: Danielle Jones, your line is open.

Danielle Jones: Hi. Yes, this is Danielle Jones from AllScripts. I do have a question as it pertains to the slides, the 278 transaction. Is that transaction included? Or is it just an oversight?

Christine Stahlecker: Well, Medicare Fee-For-Service does not use the 278 referral authorization pre-certification transaction. So, this is Chris Stahlecker answering the question, and so we did not include it our materials. It is included as a 5010 upgrade, so anyone who is using the 278 transaction and 4010A1 format today will be required to upgrade to the 5010 format.

Danielle Jones: Thank you very much for clarifying that.

Christine Stahlecker: You're welcome.

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

Liz Petsko: Hi. This is Liz Petsko from Dr. Burke's office. I'm wondering how the ICD-10 codes will affect outpatient mental health practices?

Pat Brooks: This is Pat Brooks with CMS. At this point, we don't have any proposed policy changes for that setting based on ICD-10 codes. But I would just say that every year we update our regulations for payment policies and you should watch for those regular annual update.

Liz Petsko: Thank you very much.

Operator: Your next question comes from the line of Linda D. Gregorio. Your line is open.

Linda D. Gregorio: Hi. This is Linda D. Gregorio at Winthrop Hospital. Really this question is for Pat Brooks, who is a technical expert. We were wondering with the HITECH Act, they require in, for meaningful use, they require you to develop a problem list, and our vendor is Siemens and the problem list will be written in SNOMED. Is there going to be a translation between ICD-10 and SNOMED to develop this problem list?

Pat Brooks: This is Pat Brooks and unfortunately that HITECH issue is not part of our call today. So, I'm afraid I can't respond to that. I think you should contact separately people in that area.

Linda D. Gregorio: OK. Who would I contact though?

Pat Brooks: If you send me an e-mail, I'll try to refer you appropriately.

Linda D. Gregorio: OK. Thank you.

Operator: The next question comes from the line of Cloue. Your line is open. I'm sorry, that was Jacky Cloude. Go ahead please.

- Jacky Clauda: Hi. This is Jacky Clauda. I work for Branch Orthopedics. I was wondering when I bill a patient, I bill a claim rather, for fracture prior to October 1<sup>st</sup>, 2013. When they come in for subsequent visits, would I have to change the fracture code on the claim?
- Pat Brooks: This is Pat Brooks. The simple answer, and I'm not a Part B billing expert, but if you submit a claim before October 1<sup>st</sup>, 2013, then you would use ICD-9-CM codes.
- Jacky Clauda: Right.
- Pat Brooks: If you submit ...
- Jacky Clauda: If they come again for a follow-up visit?
- Pat Brooks: If you submit a separate claim, and I do not know how this area works. If you submit a separate claim after that, then you would use ICD-10. On the detailed level of how this will work on the physician payment, I'm going to have to let you wait until we get detailed program instructions closer to that time and maybe talk to people who work in the physician payment area about that issue.
- Jacky Clauda: OK. Thank you.
- Operator: Your next question comes from the line of Janet Mievis. Your line is open.
- Janet Mievis: This is Janet Mievis with Missouri Cardiovascular Specialists. And in regards to your slide 45 where you're saying that the government now is saying you have to purchase the Implementation Guide and technical questions.
- As an individual provider's office that has a practice management system that's going to have to go to the 5010 and goes through a clearinghouse that's going to have to go to the 5010, will I at the provider level need to purchase that or is that something more for the software people that will be doing the programming and updating my systems?

Chris Stahlecker: Hi, it's Chris Stahlecker. That's really more for your vendor to know how to do the detailed programming. If you did not have the copy of the free 4010 Implementation Guide and find that useful, you really would not need to have a purchased copy of the 5010 format.

Janet Mieves: OK. Thank you.

Chris Stahlecker: So, this is something your vendor will need though.

Janet Mieves: Yes, definitely. Thank you very much.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Eddy Theoro. Your line is open. Eddy Theoro, your line is now open.

Eddie Theoro: Hi. This is Eddie Theoro from Westchester Health Associates. I'm calling in regards – asking about slide 41 where it says Medicare is going to process up to 25 diagnosis codes per electronic claim. So instead of where we're going to have six, we're going to have up to 25? I just want to verify that.

Chris Stahlecker: Well, there are two different – it's Chris Stahlecker – there are – the 837 Institutional claim has up to 25 iterations. The 837 Professional claim has 12. So, what we mean to say is that the Medicare Fee-For-Service program will be processing the maximum number of iterations that the standard format permits for diagnosis and procedure codes.

Eddie Theoro: So, depends on – if we're on the 812 or 837?

Chris Stahlecker: No, no. It depends on if you're an institutional biller or a professional biller.

Eddie Theoro: OK. We'll be for professional biller.

Chris Stahlecker: Right. That will be 12 iterations. That's what the standard format permits.

Eddie Theoro: So, it's only up to 12 then diagnosis codes?

Chris Stahlecker: Correct, correct.

Eddie Theoro: OK. OK, thank you very much.

Chris Stahlecker: You're welcome. Sorry for the misleading slide.

Operator: Once again, to ask a question, please press star followed by the number one on your touchtone phone. We'll pause once again to compile the Q&A roster.

Your next question comes from the line of Paula Angerrie. Your line is open.

Paula Angerrie: Hello. This is Paula Angerrie. And I have a question regarding the paper forms, the HCFA 1500 and the UB-04. Will there be changes to those forms for paper submitters?

Chris Stahlecker: Hey, it's Chris Stahlecker. No. There won't be any additional changes to those paper claims forms for this go around of billing. The UB-04 has already been expanded. And we'll accommodate the size of the expanded ICD-9 code value along with an indicator on whether or not it will be preceded by a zero or nine to say whether or not it's being drawn, if you're billing an ICD-9 code value or an ICD-10 code value. So – and similarly for the professional CMS-1500 claim form.

So, you shouldn't experience any, you know, paper claim form changes. You will have to place the new code value appropriately when you're billing, you know, once you do get to bill the ICD-10 code values. But the location on the claim has enough space accommodated for it on the form.

Paula Angerrie: So, is there – if we're having to submit up to 25 codes, there isn't enough space on there?

Chris Stahlecker: Oh, correct. The paper claims are not being expanded to accommodate the maximum number of iterations as the electronic claim. There is no expansion plan for the paper claim to do that. In today's world, if you do need to bill more than what the paper claim addresses, then you attach a paper claim, a supplemental page to the paper claim or you bill electronically.

Most, you know, we're over 99 percent electronic billing on the Part A side and 96 plus percent on the B side. So, most people, most entities are billing electronically today. And we do offer free billing packages by the way, just let me emphasize that. They will be upgraded for the new format. So, you'll be able to take a copy of the free billing package. And it will be upgraded to the new format, the new version of 5010 billing.

And the remittance processor, the MREP package, and PC Print packages are also being upgraded for the new format. But the paper claim is not being expanded to accommodate the new iterations.

Paula Angerrie: OK. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Jeff Enslee. Your line is open.

Marela: Hi, this is Yolo Hospice. My name is Marela. The question is this morning that since we are a Part A provider, are we considered Fee-For-service or per diem?

Chris Stahlecker: Well, it will depend upon the beneficiary that you're servicing. If that beneficiary has signed up for Medicare Part C, you would be billing an encounter. If that beneficiary had signed up for regular Medicare, you would be billing Medicare Fee-For-Service.

So it is important to know what patient types you have and what their insurance coverages are for you to prioritize your work. But in any case, all of it will need to change.

Marela: We're billing Part A. We're always billing Part A Medicare ...

Chris Stahlecker: Correct.

Marela: ... for all of our beneficiaries.

Chris Stahlecker: No, no. I understand that. It's – you will need to upgrade your system, yes.

Female: So, would this be administrated through the Medicare Administrative Contractor? We have you know, we're involved with a MAC.

Chris Stahlecker: Yes. Yes, they will. All of Medicare Administrative Contractors are undergoing system enhancements right now. They're all implementing the capability to process the 5010 versions of the transactions. And, you should be experiencing some outreach from the MACs later this year. So, they will tell you exactly how and when to start to test on the new format.

Female: OK. And we're a hospice agency. So, we're you know, we exclusively are run through the MAC for the Medicare issues.

Chris Stahlecker: Correct. Yes. They were all – the MAC...

Female: Where we were confused was you were talking about Fee-For-Service on you know, constantly and we're – and it's not a specific Fee-For-Service we're always billing under a per diem, right? That's been established.

Chris Stahlecker: Yes. But you are required to submit a claim. And that claim ...

Female: Correct.

Chris Stahlecker: ... and that electronic claims format is changing.

Female: Right. Right.

Chris Stahlecker: So, you'll experience this change as well.

Female: Well, the other issue is that we haven't been billing electronically. We key in.

Chris Stahlecker: A few do data entry to the Medicare Administrative Contractor, you can continue to do that.

Female: OK.

Chris Stahlecker: So, that the interactive screens that are Medicare Part A system, the Fiscal Intermediary Shared System or FISS, that is being expanded to accommodate the new data content. So, the screens will change, so you can expect to see

some change in your environment and so, your operators may experience, you know, a learning curve. So, the systems will all be experiencing this kind of a change.

Female: But the MAC should really be coordinating this for us or with us.

Chris Stahlecker: Yes, the MAC. That's correct. If you're using the data entry feature of FISS or if you are using a billing service to do data entry and they're converting it for you to an electronic claim to be submitted to a MAC, they would be supporting you. But if you are totally using the screens in connecting to your MAC to do data entry, yes, they will be conducting an outreach and engaging you in how to transition over to the 5010 format.

Female: And this is also just – we're also transitioning to electronic medical records and Allscripts is involved. So, I assume that they also, for the hospice format, always you know – or I heard the other Allscripts person asking the question, but it didn't sound like it was hospice related.

Chris Stahlecker: Yes.

Female: OK. Thank you.

Chris Stahlecker: OK. You're welcome.

Operator: Your next question comes from the line of Reena Yager. Your line is open.

Christine Cole: Yes. This is Christine Cole with DerMed. My question is regarding dual use for 4010 and 5010,. The way it was on prior calls is this was a take away item, and we're just wondering if you have an answer for that yet?

Chris Stahlecker: We will use the 4010 and 5010. During the calendar year 2011, our MACs are expecting that to engage in transitioning from 4010 to 5010. If a particular Trading Partner has completed testing for 5010, is your question whether or not they'll be required to convert over?

Christine Cole: Right. But it's ...



Chris Stahlecker: It's really an – it's an option for the Trading Partner to begin testing claim submissions. And when that Trading Partner will convert over to 5010 will be a secondary request to the Medicare Administrative Contractor. But, as we get into the MACs who are planning their transitions a little bit closer, you'll have more detailed information and instruction. There's an audiocast that's scheduled just for the MACs, and we'll be going over these types of questions in more detail at that time.

Christine Cole: Thank you.

Chris Stahlecker: OK.

Operator: You're next question comes from the line of Kim Welland. Your line is open.

Benita: Hi this is Benita. I'm with MaternOhio. And we have a large number of physicians and also locations, and I'm wondering what's been referenced with the P.O. Box not being available on the 5010 claims since we use a lockbox with our bank.

Chris Stahlecker: Well, it's important – it's Chris – it's important to know that the billing provider has a couple of areas where address information is reported. And a P.O. Box is not permitted in the – I believe it's the Pay To section of the claim.

You can report a P.O. Box at another location in the claim, but it will not affect where the claim payment is actually delivered. It never has affected it, it never will, from a claim submission perspective.

The location where a payment is delivered is established when you enroll in the Medicare program and those internal reference files are what are actually accessed to determine where payment is sent. It's not, determined by the actual information on the claim. Is that the nature of your question or is it ...

“Post call clarification”: P.O. boxes are permitted in the Pay To loop and not permitted in the Billing Provider loop.

Benita: I understand that Medicare covers that. My concern is with all the other private payers. So ...

Chris Stahlecker: Yes. I understand that this has gotten a lot of discussion at some of the industry settings. For the most part payers – I can't say it's universal – but in large measure, payers do not use the data that's submitted on the claim to determine where to deliver payments. That's usually established as the control on some other mechanisms in their adjudication systems.

Benita: OK. But it's still (inaudible) ...

Chris Stahlecker: But, I can't speak universally. I'm only addressing the Fee-For-Service program here today.

Benita: OK. But the P.O. Box will be available on the new format, just not in the Pay To box.

Chris Stahlecker: That's correct.

“Post call clarification”: P.O. boxes are permitted in the Pay To loop and not permitted in the Billing Provider loop.

Benita: OK. Thank you very much.

Operator: Your next question comes from the line of Lisa Lucedo. Your line is open. Lisa Lucedo, your line is now open. Your next question comes from the line of Erin Spitzner. Your line is open.

Erin Spitzner: Hi, this is regarding ICD-10. We're just curious if you know any more of how this 72-hour rule will work with the implementation of ICD-10 and if there will be any changes to that rule?

Pat Brooks: This is Pat Brooks. The two are separate and we're not prepared to discuss the 72-hour rule. We don't – there's nothing inherent in the ICD-10 that was changed or affects a policy such as the 72-hour rule.

Erin Spitzner: OK. Thank you.

Operator: Your next question comes from the line of Chuck Brooster. Your line is open.

Chuck Brooster: Hi, we've been recently reading the Federal Register, the IPPS rule that just came out, the finals, and it did say that you – that CMS would be releasing a version 28 version of an ICD-10 Grouper table. Will that include all the exclusion tables and the short descriptions, which I believe at the last conference they said would be available at some point?

Pat Brooks: This is Pat Brooks. We definitely have that issue on the agenda for the ICD-9 Coordination & Maintenance Committee meeting later this week of the 15<sup>th</sup>. We'll have handouts posted in the next couple of days with our timelines. It will include all the exclusion lists. The issues of the short titles are not resolved yet, but they will have to be resolved through the timeframes that we lay out later this week on the 15<sup>th</sup>.

Chuck Brooster: OK. And would that also include revised reimbursement crosswalks also?

Pat Brooks: If you're asking about payment policies revisions, that is part of the annual update to IPPS. The MS-DRG project is the conversion of the MS-DRG from I-9 base to ICD-10 to help the public understand how we're going about that, but there'll be regular rule making for all the annual updates to the MS-DRG.

Chuck Brooster: We were more concerned with the 10 to 9 conversion crosswalk that was available for version 26. Will that be available in 28 also?

Pat Brooks: Are you asking if we're going to update our GEMs annually- the answer is yes. And will the GEMs – and we'll be discussing this later this week on Wednesday- will the GEMs – updated GEMs be used for the version 28 MS-DRG and the answer to that is yes. And you could follow this discussion through the conference slides we'll provide for you on Wednesday morning.

Chuck Brooster: Thank you.

Operator: Your next question comes from the line of Janet Gus. Your line is open.

Janet Gus: This is Janet Gus, calling from Eyecare One. And I was wondering how the ICD-10 is going to affect optometrists?

Pat Brooks: This is Pat Brooks, and we're not prepared to discuss any payment policy changes that may happen in any setting. We simply would tell you that we're converting from I-9 to ICD-10. And any changes to payment would happen through a normal rule making (inaudible) rule making changes. So there's nothing inherent about ICD-10 that changes payment policy. Those two things are separate.

Janet Gus: The CM is different than the regular 10, correct?

Pat Brooks: ICD-10-CM is the diagnosis systems that will be used for you in a physician's office, October 1<sup>st</sup>, 2013. Yes. And I'm sorry if we occasionally modify and refer to it ICD-10. It does have two parts—ICD-10-CM which is diagnosis; ICD-10-PCS which is procedure.

Janet Gus: Is there going to be a manual out for the 10 – no, the 10-CMs for us to reference?

Pat Brooks: Yes. As a matter of fact some private publishers already sell to ICD-10-CM books, you can Google it and find out if it sells one now.

Janet Gus: OK.

Pat Brooks: Or if you just want to browse a complete ICD-10-CM, you can look at CMS' website on the slide as provided for you and you can find the whole coding system today.

Janet Gus: OK. I guess, I just – we have multiple locations and multiple doctors and I just have a hard time thinking that they're going to be able to figure this out on their own without something black and white in front of them.

So, the procedure codes are changing also; is this what I'm understanding?

Pat Brooks: All right. You're in the physician's office so you don't have to worry about that because the ICD-10 procedure code system will only be used by hospitals

for their claims. So what you do have to worry about – I'll defer to Sue if she wants to give you a couple of points, how she would advise you to start training your physician staff about ICD-10-CM, which your physicians staff will be using for their claims.

Sue, do you have a few points to add?

Sue Bowman: Well, I would just suggest there are actually a lot of resources both on AHIMA's website that was listed in this presentation, other organization's websites- CMS, the CDC- that do provide a lot of guidance for sort of starting the educational process.

I do agree it's a big job and there's a lot of education to do and you'd be well advised to get started. But one way to cut it into chunks and to make it easier is to realize that obviously optometrists don't use the entire ICD-10-CM or ICD-9-CM, either one, all of the codes, in that they focus in certain areas like the eye. And, so that you could really start at looking at what is the most common diagnosis codes they use today and how would those conditions be coded in ICD-10-CM and focus their education that way to start off with.

Janet Gus: Are there routines codes also and not just medical codes in the ICD-10?

Sue Bowman: What do you mean by ...

Janet Gus: Because most of our claims are routine.

Sue Bowman: You mean like what would be considered V codes in ICD-9 today? Is that what you're talking about?

Janet Gus: Like the diagnosis code for a routine pair of glasses, they'll be just looking at the prescription and you know, or 367.9 or 367.4. Just like myopia or presbyopia that type of thing, they're routine reasons for the glasses or a routine exam.

Sue Bowman: Right. There's actually, there's still – whatever those conditions codes were in ICD-9 there are still conditions for in ICD-10-CM as well ...

- Janet Gus: So our routine (inaudible), OK.
- Sue Bowman: ... including administrative visits and routine visits and that kind of thing.
- Janet Gus: OK.
- Sue Bowman: That area is actually very much expanded in ICD-10-CM.
- Janet Gus: OK. Thank you.
- Pat Brooks: All right. Simon, we have time for one more question.
- Operator: Your next question comes from the line of Nancy Benning.
- Nancy Benning: I just have a quick question. I want to clarify if on an inpatient admission if the patient was admitted like on September 15<sup>th</sup> and discharged on October 5<sup>th</sup>, did you say that the entire admission would be build using ICD-10?
- Pat Brooks: This is Pat Brooks. Yes, that's exactly what I said. Today hospitals bill based on the discharge date; they used the codes in effect for the discharge date. The same will be true for ICD-10. So on October 5<sup>th</sup>, 2013 when the patient is discharged, you'll know that you should use ICD-10 codes to code that claim.
- Nancy Benning: OK, great. Thank you very much.
- Hazeline Roulac: OK, thank you. Unfortunately, that's all the time we have for questions today. We've received a lot of good information. And, before we end the call, for the benefit of those who may have joined the call late, please note that continuing education credits may be awarded for this call by the American Academy of Professional Coders or AHIMA.
- So, please refer to slide 54 and 55 of the slide presentation for more information. If you have any questions regarding the rewarding of credits for this call, please contact your particular organization.
- And, as Sue indicated, we encourage you to retain your presentation material and confirmation e-mail should you be audited.

We would like to thank everyone for participating in the ICD-10 Implementation in the 5010 Environment Follow-up National Providers Conference Call.

And we'd like to remind you that a written and audio transcript of today's call will be posted through the CMS Sponsored Calls section of the CMS ICD-10 web page at [www.cms.gov/icd10](http://www.cms.gov/icd10). The audio transcript should be available in approximately a week, and the written transcript will follow in about two weeks.

We thank our speakers Pat Brooks, Christine Stachlecker and Sue Bowman for being here. We appreciate them taking the time to be with us today. And this ends our call for today. Please have a wonderful day.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

END