Centers for Medicare & Medicaid Services
Preparing for ICD-10 Implementation in 2011 National Provider Teleconference
Moderator: Leah Nguyen
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1:00 p.m. ET

Welcome

Operator: Welcome to the Preparing for ICD-10 Implementation in 2011 National Provider Teleconference 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 participating in today's call. I will now turn the conference call over to Ms. Leah Nguyen. Ma'am, you may begin.

Leah Nguyen: Thank you, Shannon. Hello I'm Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Preparing for ICD-10 Implementation in 2011 National Provider Teleconference.

Subject matter experts will review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies for this year. At the end of the presentation, we will open up the phone lines to give you an opportunity to ask questions of our subject matter experts.

Before we get started, there are a few items that I need to cover. There has been a tremendous amount of interest in this call, and we apologize that we are not able to accommodate everyone who tried to register.

This call is being recorded and transcribed. An audio recording and a written transcript will be posted to the CMS Sponsored ICD-10 Teleconferences section of the CMS ICD-10 website in approximately one to two weeks following this teleconference. The website address is www.cms.gov/icd10.

There are two handouts for this session, a slide presentation and a special edition MLN Matters Article, SE1033. 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. At the left side of the web page click on CMS Sponsored ICD-10 Teleconferences. Select the January 12, 2011, call and scroll down the page to the Download section for the slide presentation and the Related Links Inside CMS section for the article.

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 teleconferences.

Please see slide 61 and 62 of the slide presentation for more information. If you have any questions regarding the awarding of credit for this teleconference, please contact that organization. We encourage you to retain your presentation materials and confirmation e-mails.

We have a lot to cover today, so without further delay we will get started. At this time, I would like to introduce our two speakers who are subject matter experts on ICD-10. We are pleased to have with us Pat Brooks, Senior Technical Advisor in the Center for Medicare, Hospital and Ambulatory Policy Group at CMS, and Sue Bowman, Director of Coding Policy and Compliance at the American Health Information Management Association or AHIMA.

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

Slides 3 thru 29

Pat Brooks: Thank you. I'll begin with slide three where we discuss implementation dates for ICD-10. October 1, 2013, is the compliance date for implementation of ICD-10-CM. That's the diagnosis part of ICD-10 and for ICD-10-PCS, the procedure part of ICD-10.

Please note that there will be no delays with this implementation period. And, in addition, there will be no grace period. The reason – one of the reasons for the call today is because the date is approaching and we hope to encourage you to begin your implementation planning activities if you have not done so already.

Going on to slide four, we'll point out once again the fact—there is no grace period. So providers will not be able to continue reporting ICD-9-CM codes

for services that are provided on or after October 1, 2013. There will be no delay in the implementation date of ICD-10.

Slide five illustrates the use of these ICD-10 codes in various settings. ICD-10-CM the diagnosis will be used by all providers in every health care setting. So if you're using ICD-9 diagnosis codes for anything now, then you need to be aware that you will be impacted on October 1, 2013, because you will replace the ICD-9-CM diagnosis codes with ICD-10-CM codes.

ICD-10-PCS is the procedure part of ICD-10, and it will only be used for hospital claims and for hospitals claims which are for inpatient hospital procedures only. It will not be used by hospitals for their outpatient claims.

A source of some confusion is—people have asked us if physicians who do inpatient visits to see their patients, if on physician claims they will have to use ICD-10-PCS for those inpatient visits on their claim. And the answer is no. ICD-10-PCS will not be used on physician claims, even for those inpatient visits.

So physicians that are providing inpatient services, they will continue to bill in the same way they are now. They will use CPT and HCPCS. Physicians will not have to learn this code with ICD-10-PCS for their claims because they will not be using ICD-10-PCS on their claims.

Moving on to slide six, this slide reinforces this area and mentions that there will be no impact on HCPCS or CPT codes use with the implementation of ICD-10. Both of these coding systems will continue to be used as they are now.

On slide seven, we discussed the exact way this will be implemented. There is a single implementation date for ICD-10 for all users and that is October 1, 2013. And it will be the date of service for ambulatory and physician reporting.

So if a patient is seen in the ambulatory setting or a physician office on or after October 1, 2013, then these claims will be billed using ICD-10-CM

diagnosis codes. As we discussed earlier these ambulatory physician services will continue to CPT and HCPCS as usual.

Now for inpatient, the way that's going to work is that we would use the date of discharge for the implementation of ICD-10. So inpatients that are discharged on or after October 1, 2013, the hospital will use both ICD-10-CM and ICD-10-PCS for these inpatient claims.

Moving on to slide eight, a frequent question we have is some people wonder if they could supply ICD-9 codes after the implementation or ICD-10 codes before the implementation dates. And these two bullets say no, that's not acceptable. ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.

In addition, ICD-10 codes will not be accepted for services provided prior to October 1, 2013. In other words you cannot decide to submit ICD-10 codes earlier than the implementation dates. You must stick with that date of service. Slide nine gives information about ICD-10 being different from ICD-9 codes. ICD-10 codes have much greater detail in describing both diagnosis and procedures.

There are also many more ICD-10 codes than there are ICD-9 codes. In Addition to that, ICD-10 codes are longer and they use more alpha characters. For those of you who want more details about what ICD-10-CM is all about, I would refer you to an outreach call we had on March 23, 2010, where we covered ICD-10-CM basics. This gives a very good overview of what ICD-10-CM diagnosis are all about.

There are slides and there are audio and transcripts. You can even take those slides and reconfigure them yourself and do your own internal training should you want to do so. Obviously with these codes being longer, and having more alpha characters, the systems are impacted. And they have to be updated. We've had two outreach calls on the issue of the system changes that will be required prior to moving to ICD-10.

So those of you who would like to know more about the impact of 5010 and the need to change systems I would encourage you to go to our ICD-10 Website and listen to the following outreach calls. There was one on 5010 and ICD-10 on June 15, 2010, and a follow up one on September 13, 2010. And I think this will answer many of your questions about the systems changes that are necessary to move forward.

Moving to slide 10, we show that we put annual updates to the ICD-10 coding system each year. In December we posted the 2011 updates to both ICD-10-CM and ICD-10-PCS. For those of you who have not yet looked at them I encourage you to do so. These files particularly the ICD-10-CM files you can open up the regular tabular parts and you can also look into the index section. So you can just see what it looks like.

The same is true of ICD-10-PCS. And that's more of an interactive coding systems that you can review. Now the maintenance and updates of both ICD-9-CM as well as ICD-10 are discussed at meetings of the ICD-9-CM Coordination and Maintenance Committee, sometimes referred to as the C&M Committee. So, if you're curious about how new codes are created or how to go about requesting new codes, then I would urge you to look at that website for the ICD-9CM Coordination and Maintenance Committee.

You can even download audio and written transcripts of the last meeting. And you can even see a summary report and handouts. You could follow all the activities of the committee by going to this website. Each meeting of the coordination and maintenance committee discussed both ICD-10 updates as well as ICD-9. We're now moving to slide 11 where we discuss tools to help you convert ICD-9 codes as fast as you can.

As I mentioned earlier ICD-9-CM codes are quite different from ICD-10's. So it was necessary to develop some tools to assist in converting these codes. We developed the general equivalent mappings also referred to in GEMs to assist in converting data from ICD-9-CM to ICD-10. And these are basic mappings force, for instance taking codes from ICD-9 and finding equivalent ICD-10 codes and they're also backward mappings taking ICD-10 codes and finding the equivalent with ICD-9.

For those of you who are interested in GEMs, then I give you the website ICD-10 on the left side you can find the GEMs for both the ICD-10-CM diagnosis codes as well as the ICD-10-PCS procedure codes. And we just posted the 2011 version of those. When you open those files you will see that we zipped some additional files together that are quite useful. One is the User Guide of how to use the GEMs.

I would encourage you to review that first. We also have a document called GEMs Summary Sheet. It's sort of like a quick cheat sheet to tell you how to approach taking a list of codes and converting it and what kind of file you would open. Also on that website we have a link to the MS-DRGs conversion projects. I've given you the websites for that on slide 11.

This is an illustration of how CMS has taken the GEMs, the general equivalence mappings, and begun a very large scale conversion project converting the MS-DRGs, the payment systems for inpatients for Medicare, converting that from ICD-9 base to ICD-10 base. We have reported on our progress, how we went about it, lessons learned, what we suggest others do when they have such a large scale project, the kind of staff we involve.

You will find a detailed paper describing all of those issues on that website in addition to the actual mappings of the MS-DRGs. And by February, we will be posting an updated version of the MS-DRGs to match our current version of the ICD-9-CM MS-DRGs. Those of you who want to have a little more information about the GEMs and their use, can also listen to one of our previous outreach calls on the GEMs that was held on May 19, 2009.

In addition we had an outreach call on the conversion project of converting the MS-DRG on November 19, 2009. Subsequent to that we've had discussions at the ICD-9-CM Coordination and Maintenance Committee, and in particular you might want to review the transcript and the handouts from September 2010 Coordination and Maintenance Committee where converting and moving to DRGs and ICD-10 based was extensively discussed.

Moving on to slide 12, we have to be aware that learning to use the GEMs is not a substitute for learning how to code. Many of you will probably never use the GEMs and will have a need to. You will simply learn how to use ICD-10 coding system and you will begin coding on the appropriate date and you will catch your information using ICD-10s.

Others of you may have a small conversion project that you will be asked to do where you've captured perhaps maybe diabetes codes previously. And your supervisor may say to you I need for you to convert this project. We need to have all the ICD-10 codes for that.

Well you can use the GEMs, they'll be a good tool in helping you focus in. Or you might just find it quicker simply to open up an ICD-10-CM code book and find the accurate codes. So I would urge you if it's a small project to consider that it might be quicker and more accurate to simply work with the code books instead of the GEMs.

Moving to slide 13, we will discuss a provision in the Affordable Care Act. Section 10109(c) requires the Secretary of HHS to task the ICD-9 Coordination and Maintenance Committee to obtain input regarding the crosswalks between ICD-9 and ICD-10, which we refer to as the GEMs, the General Equivalence Mappings.

We were to get input at this public meeting and then make appropriate revisions to the GEM. We did discuss GEM updates at the September 15, 2010, Coordination and Maintenance Committee meeting and got a lot of very good suggestions. For those of you who once again want to read about that, the auditory and written transcripts and handouts are posted on that website.

We allowed the public additional time through November the 12th to send any additional comments or recommendations on how to update the GEMs. We carefully reviewed all of those comments and then we prepared the 2011 version of the GEMs and posted those on our website. So the Affordable Care Act requirements are now satisfied with these crosswalks.

Moving to slide 15, I'll just point out as I mentioned before the 2011 update to ICD-10-CM, ICD-10-PCS, and GEMs are posted on the website. And in addition, we have also posted the reimbursement mappings to that website for 2011. You can find all these on that website on the left side of the ICD-10 Website.

Moving on to slide eight, we'll discuss the partial code freeze. We have included one of the postings with the MLN Matters on this that we sent out previously to discuss the freeze. Annual updates to ICD-9-CM and ICD-10 codes that we have each year have made transition planning difficult for many and people that are converting their internal systems when they're changing each year, it made that even more difficult to handle.

We had numerous requests from vendors, system planners, payers and educators to have a code freeze. We discussed this issue at multiple meetings of the ICD-9 Coordination and Maintenance Committee and solicited additional written comments. You can read in previous meetings about those discussions. There was consensus for a partial freeze of both coding systems. And thus that freeze is described in both the MLN Matters and also beginning on slide 17.

The last regular annual update to both ICD-9-CM and ICD-10 will be made on October 1, 2011. At our March 9 through 10, 2011, ICD-9 Coordination and Maintenance Committee, we will be discussing these last major issues before the freeze is implemented.

Then we will have the last update on October 1, 2011, based on this March meeting. On October 1, 2012, there will be only limited code updates to those ICD-9 as well as ICD-10 codes. And they will only be created to capture new technology and new diseases.

On October 1, 2013, there will only be limited codes to ICD-10, which will be capturing new technologies and new diseases. On slide 18, we show that they'll be no updates to ICD-9-CM on October 1, 2013, because the system will no longer be a HIPAA standard. And then beginning on October 1, 2014, regular updates to ICD-10 will begin.

Moving to slide 19, the ICD-9 Coordination and Maintenance Committee will continue to meet twice a year during the freeze in March and September of each year. At those meetings the public will comment on whether new codes that are discussed should be created during the freeze.

And the criteria will be whether or not these are new technologies or new diseases. Any codes that do not meet the criteria of being a new technology or a new disease will be held for consideration for inclusion in ICD-10 after the freeze ends.

And once again following the ICD-9 Coordination and Maintenance Committee, it's important to do reviewing the summary reports and submitting in your comments of things discussed at that meeting, you can do so by going to this website.

We plan to have a limited number of conference lines for those of you who would like to listen to the meeting for the March 9th through 10th meeting. And we'll be posting the information on how you register for those phone lines sometime in February so watch that website if you would like to listen to those meetings.

Moving on to slide 22, we've had questions and perhaps some misunderstanding about how unspecified codes will be handled with ICD-10. There seems to be an impression that perhaps they will be handled differently with the ICD-10 than they are with ICD-9. And this is not the case.

Current payment and coverage policies include unspecified codes with ICD-9-CM. And as we all know, ICD-10 codes will also have unspecified codes, so there's no change in that fact. Payers, including CMS, will continue to make independent judgments about how specific codes that are considered unspecified codes should be handled under a payment or coverage policy.

Currently sometimes they are paid for and handled one way within a coverage policy and they may continue to be handled that same way under ICD-10. It's an independent judgment based on the payment policy. There is no carte

blanche statement that unspecified codes are unacceptable with ICD-10. One should use - they are being handled in a similar fashion as to the way they're handled now with ICD-9.

Moving to slide 23, as you know we have begun work on the MS-DRG Conversion Project. We were quite early in that, learning how to do it well so that others could learn from within CMS and outside so that others could be able to convert their payment and coverage policies, edits and additional things that need to be converted.

We've had numerous questions about when their payers, other parts of CMS will have their information converted and ready to share. And that will be released once additional things are finalized and as payers make their decisions.

As far as CMS goes for specific payment policy, we will continue our usual formal rule making for payment policy. And it will involve the ICD-10 MS-DRGs in that formal rule making process for our FY 2014 update, which is the implementation of ICD-10 on October 1, 2013.

So those of you who sent advanced questions asking if timelines will change on claims – the way claims are handled or how will auditing be done, will that be different. We don't have any information on that at this point. As information is developed, it will be shared.

The remainder of my presentation, I just want to point out that we've tried to put together a number of slides that showed some valuable resources for you to use. Slide 24 is the general ICD-10 as well as MS-DRGs Conversion Project website and then a very important site on the bottom of 24 for those of you who are interested in a lot more detail on 5010 systems issues.

Slide 25 shows a place where you can go to get resources and also the very important teleconference web page. And so, as we schedule future teleconferences, we will post announcements on that teleconference web page. After the meeting we will be posting audio and written transcript along with the handout.

The bottom of slide 26 shows additional Medicare Fee-for-Service Provider Resources and Provider Resources. You can find some very powerful fact sheets that you might want to use for training within your facility. Slide 27 shows other types of information that you can find on the ICD-10 Website.

Slide 28 is useful because people frequently ask us where can I get various products that have been developed for ICD-10. WEDI and HIMSS have agreed to list any providers, resources or products on their website. So if you want to go look at these websites you can to learn what's available. If you have a resource that you would like them to post then you can contact either WEDI or HIMSS and ask about the possibility of including your resources on their website.

I'll now turn the speaking over to Leah.

Leah Nguyen: Thank you, Pat. Our next speaker is Sue Bowman, Director of Coding Policy and Compliance at the American Health Information Management Association or AHIMA. Sue will be speaking with us today in her role as one of the ICD-10-CM Cooperating Parties. The Cooperating Parties represent a longstanding public and private sector partnership with 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. I now turn the call over to Sue.

Slides 30 thru 62

Sue Bowman: Thank you, and I'll start on slide 30. I know that many of you are very familiar with the differences between ICD-9 and ICD-10. But for those of you who may not and for a little refresher, I thought we would just start very briefly with a description of the difference in the structure between the two code sets.

So for ICD-10-CM, the codes are three to seven characters long, whereas we all know they were only up to five characters in ICD-9. The character one in

ICD-10-CM is always alpha. All the letters except U are used. Character two is numeric. Characters three through seven can be alpha or numeric.

Just as in ICD-9-CM there is a decimal after three characters. ICD-10-CM also uses a new concept called a dummy placeholder of X to conserve space to allow future expansion in some code categories. And the alpha characters are not case sensitive, meaning that a lowercase letter and an upper case letter do not have different meanings, they have the same meaning.

On slide 31, just a brief description of the differences between ICD-10-PCS and ICD-9-CM is that as you can see PCS is a much longer code, much more room for expansion and for specificity than we currently have in ICD-9 procedure codes. And every code in PCS always has exactly seven characters.

Each character can be either alpha or numeric. The numbers zero through nine and the letters A through H, J through N and P through Z are used. The letters I and O are not used. Alpha characters again are not case sensitive. As I said, each code must have seven characters. And there is no decimal in 10-PCS. So that's just a little brief background to set the stage for some of the differences in the code set that have to be taken into consideration as we get into implementation planning.

Now on slide 32, as I'm sure many of you have already realized, the transition to ICD-10 presents many opportunities as well as challenges. The scope and complexity of the transition are very significant, coded data are more widely used now than when the U.S. transitioned to ICD-9 almost 30 years ago.

And given all of the places where ICD-9 codes appear or are used in some way, the transition to ICD-10 requires extensive changes that will affect many systems, processes and people. So a key takeaway message from today's session is the absolutely critical importance of not delaying in getting this implementation process started.

A smooth, successful transition by the compliance date of October 1, 2013, requires a very well planned and well managed implementation process. An organization that has planned their implementation strategy carefully and

thoroughly and begun the planning process early can expect a smoother transition and earlier realization of benefits from moving to ICD-10.

The implementation planning and preparation process can be thought of as being broken down into several phases. The first phase, which is the one I'm going to focus on mostly today is implementation plan development and impact assessment. And ideally this phase should be nearing completion or at least well underway.

So for those of you who may not have gotten started yet or have just barely gotten started, I urge you to move forward with this phase as quickly as possible. As I'll explain as we talk through some of the steps in this phase, it's critically important to start this phase quickly because it will set the stage for how much work and how much time is necessary for the steps that need to be done in the subsequent phases.

In other words until you know the scope of the impact of ICD-10 in your organization, you don't know how much time and resources are going to be needed to complete the preparation activities. So you don't want to wait too long before making that assessment.

Phase 2 is the implementation preparation phase. It can be thought of as putting into action the tasks for implementation that are identified in Phase 1. Phase 3 is the go-live preparation immediately prior to the compliance state. Phase 4 is actually post-implementation. After October 1, 2013, there will still be follow-up activities, problem resolution and so forth that need to be done.

And these phases are not mutually exclusive timelines. They will very likely overlap. On slide 34, it's sort of a suggested timeline for the different phases with the first phase really having begun once the ICD-10 final rule was issued. I should point out that the quarters referenced in these dates refer to calendar year quarters.

So, for example, first quarter 2011 is referring to January to March of 2011, just for clarification. These dates are only a general guideline. The timeline for the implementation plan development and impact assessment,

implementation preparation and go-live preparation will likely be variable to a number of – due to a number of factors including the type, size and complexity of the organization.

However, as I mentioned completion of the impact assessment early is critically important because without the impact assessment an organization cannot reasonably predict the length of time or the amount of resources that are going to be required for the implementation preparation and go-live phases and, therefore, can't plan an accurate timeline or budget for the work involved.

So delayed completion of this impact assessment phase will jeopardize an organization's ability to complete all of the ICD-10 implementation tasks by the compliance dates which will risk increased claim rejections and payment delays.

On slide 35, as I said we're going to focus today on the major steps that need to be done in Phase 1 to help those of you who may be struggling with getting started to understand what these steps are and how to move forward with this planning phase. A key first step is establishing an interdisciplinary steering committee to develop the ICD-10 implementation strategy for your organization and oversee the implementation process.

Essentially this committee will be responsible for overseeing all of the steps in the ICD-10 transition process. Membership on this committee should include representatives from the various business areas impacted by the ICD-10 transition. Now note that in a small organization such as a physician practice or a clinic this committee might just be a couple of people. But it is still some designated people who are responsible for overseeing and managing the transition process.

The steering committee is charged with formulating transition strategies and identifying the goals and this will include development of the organization's ICD-10 implementation strategy and identifying the actions, people responsible and deadlines for the various tasks required to complete the transition.

And ICD-10 awareness education should also be provided to key stakeholders that are identified by the steering committee and I'll talk about this in more detail a little bit later in the presentation.

Change management strategies need to be implemented to empower the stakeholders to accept and embrace the transition to ICD-10 and this is a key step in this phase to overcome resistance to change, get everyone on board and make everybody feel like they're part of the process for moving forward and not resentful of it.

Also during Phase 1 the key ICD-10 transition tasks and objectives should be identified. Next, on slide 37, a detailed project plan should be developed. That includes an internal implementation timeline and specifying the resources required to complete the various identified tasks, articulating all of the stakeholder's roles and responsibilities and spelling out the transition tasks, deadlines and responsible individuals, essentially all of the normal steps that would be part of developing a plan for any large project.

I had mentioned earlier that ICD-10 awareness education should be provided, and this is basically to alert the various key department heads and managers and senior executives throughout your organization about the transition to ICD-10 and some key information that they need to understand in order to move forward with this project.

So, for example, senior management information technology personnel, key department managers, the medical staff need some education on what is the ICD-10 regulatory requirement, the information that Pat presented earlier, what is the value of going to these new code sets. In other words why are we doing this?

What do we hope to accomplish in the end? How does ICD-10 fit with other internal and external initiatives and just some of the overall key differences between the ICD-9 and the ICD-10 code sets and also between ICD-10-CM and ICD-10-PCS?

In addition to educating the medical staff on the general regulatory requirements, the value of the new code sets and how ICD-10 fits with other initiatives. They also need to be made aware of the impact of ICD-10 on their documentation practices.

Coders and other health information management professionals need to begin to become familiar with the structure, organization and unique features of ICD-10-CM and/or ICD-10-PCS, depending on their setting as Pat explained earlier—who's going to implement which system. Only coders in hospital inpatient settings will need to learn about ICD-10-PCS, whereas coders in all settings will need to become familiar with ICD-10-CM.

Note that the level of education I'm talking about here, this familiarity with the code sets is not the same as the intensive education on actually learning to code with 10-CM and 10-PCS. That needs to be provided closer to implementation and that I'll touch on a little bit later.

Also note that when I refer to coders throughout this presentation this really encompasses anyone who will be doing the actual coding of encounters or services such as physicians who may do their own coding or office managers or other personnel who aren't necessarily called coders but are serving in the capacity of the coder.

If they're doing the coding of an encounter and that's part of their responsibility or what they do, then the timelines we're talking about here for the kind of education coders need to have and when that needs to occur applies to those individuals as well.

Next in Phase 1 needs to be an assessment of the organizational readiness for the transition. This is a big area, a big chunk of the Phase l activities. This includes things like identification of the affected business areas and individuals, identification of all of the affected systems, applications, databases, consideration of current and future organizational plans and acquisitions such as mergers, purchases of physician practices or healthcare facilities, impact on all of the operational processes that currently use ICD-9-

CM codes needs to be analyzed as well as those processes for which ICD-10–CM or ICD-10-PCS codes are intended to be used in the future.

In other words where is ICD-9 today and where might those ICD codes need to be used in the future? The impact on documentation processes and work flow needs to be assessed. And you should evaluate the current data flow, work flows and operation processes to identify those impacted by the ICD-10 transition and determine areas where you can make improvements in those processes.

In other words you may not want to just convert all your current processes to ICD-10. You may look at the processes and see that there are some areas that can be improved and made more efficient, and while you're doing the ICD-10 conversion would be a great opportunity to do that. And, as I mentioned earlier, delayed completion of the impact assessment will jeopardize the ability to complete all of the ICD-10 implementation tasks by the compliance date.

So it's critically important to get started on this step if you haven't already done so. Other steps in this area include identifying all of the reports and forms requiring modification for ICD-10, any policies and procedures that need to be developed or revised, and looking at the status of the readiness of your business associates.

This would include people like the systems vendors, payers, other providers that you do business with and communicating with them to see their progress towards ICD-10 preparedness and understand when they expect to be ready for testing. And one point I'd just like to make about this whole impact assessment area is that a lot of organizations we've talked to have indicated a surprise that all of the areas within their organization that they have found are impacted by ICD-10.

I haven't talked to anybody yet who dug into this and discovered that really ICD codes are not used as extensively or infiltrated throughout their organization as much as they expected. Most people are finding that you would be very surprised at some of the places that are impacted by the

transition. And so this project is bigger than they expected and so the earlier you understand that, so that you've allowed sufficient time to actually make the changes, the better off you'll be and the more prepared you'll be for the compliance date.

All of the internal and external recording processes that might be impacted need to be identified. These include processes such as registries, quality measures, state data reporting requirements, the impact on coding and billing productivity needs to be assessed, such as figuring out how long it's going to take for coders to achieve proficiency in ICD-10 coding and what the impact of that learning curve will be on the quality of data due to a temporary decrease in coding accuracy during the learning curve.

The length of this learning curve and the impact on data quality is expected to be less for ICD-10-CM than for ICD-10-PCS due to the similarities to ICD-9-CM . But certainly in both systems there's going to be a learning curve for coders to become proficient in the new systems. ICD-10 implementation experience in other countries has shown that an initial productivity declines should be expected with a gradual improvement over three to six months.

Implementation variables that can affect productivity are the amount and level of dedicated preparation, program management, interdisciplinary team participation, extent of coder education and credentials, coder experience and understanding of anatomy and disease processes, extensive training, documentation status and organizational size and complexity. You also need to start to asking your vendors about their readiness and timeliness for upgrading the software.

For example some of the questions to ask vendors include what systems upgrades are replacements are needed to accommodate ICD-10? What costs are involved and will upgrades be covered by existing contracts? If not, what will be the projected cost and when will the cost be incurred? When will upgrades or replacement systems be available for testing and implementation? What customer support and training will be provided?

And how will their products and services accommodate both ICD-9 and ICD-10 as you work with claims provided both before and after October 1, 2013? The information technology personnel need to be oriented on the code set specifications and pertinent regulatory requirements including the logic and hierarchical structure of ICD-10-CM and ICD-10-PCS.

Some of the things to consider here include the fact that the compliance date is date of service driven. Remember as you look at the different data fields where ICD-10-CM will be a factor and where ICD-10-PCS will be a factor. For example outpatient procedure code fields will not be affected because they will still contain CPT codes. Facility-wide systems audit needs to be performed which means inventorying all of the systems applications and databases using ICD-9-CM codes.

And this can be a big job if you have a lot of systems. Some of the things to consider here are how many systems will be affected and what types of systems will be – systems changes will be made? Is the system developed and maintained in house or by an outside vendor? Is an application service provider used for any of the applications? How are ICD-9-CM codes used in each system? Where do ICD-9-CM codes originate from? How is the quality of data in the system checked?

A detailed analysis of all of the system changes that need to be made will need to be performed. And then the system changes need to be prioritized and the costs of making these changes estimated. The electronic data flow needs to be mapped to inventory all of the reports that contain ICD-9 codes. For example, who is using these reports?

Are these reports even still needed? Is anybody even reading them? Do the reports contain the information users really need and are completely new or modified reports needed instead?

Again, as I said, this is an opportunity to look at all of the processes and reports that are currently in existence and make sure that what you're producing and what you continue to do is really the best way to go for the organization.

On the next slide, slide 45 – there is a list of some of the systems and applications potentially affected by the transition to ICD-10. This is certainly not an all-inclusive list, but gives you an idea of the scope of the task that you're facing. You need to determine, as part of the overall systems impact, how long both ICD-9-CM – ICD-10 codes will need to be supported, and if system storage capacity will need to be increased.

Will any upgraded or new hardware or software be needed? And be sure you consider any systems currently under development to make sure that it's flexible enough to ensure compatibility with ICD-10. On slide 47, moving into the coding area of this impact assessment and implementation planning – a gap analysis of coding and documentation practices should be conducted.

This means starting now to measure the coder's baseline knowledge of anatomy, physiology, pharmacology and medical terminology, so that education can be targeted at the areas of identified weaknesses. And, measuring the coder's baseline knowledge now will shorten the learning curve, improve the coding accuracy and productivity, and accelerate the ultimate realization of benefits from moving to ICD-10.

This step involves assessing the coder's knowledge in all of the biomedical sciences, as I mentioned, and then providing any additional training as needed, based on the assessment results. So this is the type of training that can be done now – that doesn't have to wait until the intensive coder training closer to implementation, where you can make sure that the coders are adequately prepared with the expertise in the biomedical sciences arena well before ICD-10 is implemented.

The quality of medical record documentation needs to be assessed and this can involve evaluating samples of various types of medical records to determine whether the documentation supports the level of detail found in ICD-10. And then, documentation improvement strategies can be implemented to address areas where documentation is found to be lacking.

Changes in documentation capture processes might be considered, such as prompts from electronic health records systems to help facilitate improvements in documentation practices. And it helps in this step to designate a physician champion to assist in medical staff education and promote the positive aspects of moving to ICD-10.

And, as Pat mentioned earlier, keep in mind that there will still be unspecified codes available, so the goal here is not to eliminate the use of all unspecified codes – there are times when even the clinician doesn't have the information necessary about the disease process in order to assign a more specific code.

But the goal here is to ensure the medical record documentation is as good as it can be to support the greater specificity in the ICD-10 code sets to the absolute extent possible, and it's best to do that early on, rather than wait for implementation, and then deal with a lot of issues with the documentation at the same time that ICD-10 is also being used – better to have the documentation already improved up front and ready to go when the compliance date arrives.

The training needs need to be assessed, and this isn't just coders. Multiple categories of users of coded data are going to require varying types and levels of ICD-10 education and it's going to be needed at different times. Different people will need different training at a different point in time between now and the compliance date, so you need to determine, who's going to need education in your organization?

What type and level of education do they need, based on their role? And when that education needs to occur – what is the most appropriate and cost-effective method of providing the education to these different categories of individuals? Such as, traditional face-to-face classroom teaching, audio conferences, self-directed learning programs, web-based instruction, et cetera.

Will this education be provided through internal or external mechanisms, or a combination of both? And, of course, the same method of training doesn't need to be used for every group that requires training. Different groups may benefit from different styles and methodologies of training.

On slide 50, as I mentioned earlier, now is not the time to provide intensive coder training, meaning the training to teach people how to learn to code with the system. We recommend that that not be provided until six to nine months prior to implementation – and the main reason for that is, if coders are trained now and they're not using that training until, of course, October 2013, they're going to lose a lot of that knowledge in that interim.

So, while they need to become familiar with the code sets – understand the differences in the systems, some of the key issues involved with coding with ICD-10 – it's really not the time now to provide that intensive training.

When it is time to provide the intensive training, it's expected that – for budgetary purposes – to consider two full days of ICD-10-CM training for those who just need ICD-10-CM and not ICD-10-PCS because ICD-10-PCS is so completely different from ICD-9-CM, it will require more training that ICD-10-CM and, as was stated in the ICD-10 final rule, it's anticipated that approximately 50 hours will be needed to fully train hospital inpatient coders on both ICD-10-CM and ICD-10-PCS .

Slide 51 provides some examples of some of the categories of individuals within your organization that may need some level of ICD-10 knowledge, not necessarily intensive coder education, like the coders will need, but some level of knowledge about the ICD-10 code set in order to understand that the data that they are using in their particular position.

Part of Phase 1 is also developing an ICD-10 budget. This involves identifying all of the ICD-10 transition expenses and estimating if there are associated costs, such as software modification, education, hardware and software upgrades, staff time, temporary or contract staffing to assist with increased work resulting from the transition, such as coding and billing backlogs, IT support, or review of coding accuracy.

The amount of anticipated cost for the ICD-10 transition is dependent on the size and complexity of the organization, as well as the degree of system integration, the need for outside technical assistance, and the number of

systems, applications and interfaces that need to be updated. The largest budgetary expenses, however, are generally for the systems upgrades and education.

Other possible transition expenses include consulting services, report redesign or development of new reports, reprinting of paper forms, conversion of data, and additional software or other tools and resources to facilitate the ICD-10 transition or improve operational processes.

And, as part of this process, you need to identify the departmental budgets that will be responsible for each transition cost, including the systems changes – hardware, software upgrades, and education – where the budget for that is going to appear. So that was really the focus on Phase 1, which was, in a nutshell, assessing the impact, discussing the scope within your organization of what needs to be done to prepare for ICD-10.

Just briefly, I'll touch on Phase 2, implementation preparation, which should ideally start about now or very shortly, and essentially involves completing the tasks that were identified during Phase 1, including implementation of system changes, making the actual changes in policies and procedures, reports and forms that were identified in Phase 1 or developing any new reports, providing education to those categories of individuals I mentioned earlier once you've identified who needs training and when, then some of those groups whose training needs to occur earlier, rather than later, may need to begun – may need to be started during this time period.

Also, as part of Phase 2 – is implementing the documentation improvement strategies that were identified in Phase 1, and continuing to monitor the documentation improvement and making further changes as necessary – completing the internal testing and validation of system changes occurring sort of later on in Phase 2, and then, once systems, vendors, payers, or other business associates are ready for testing, to begin the testing process.

The assessment of medical records documentation and implementing improvement strategies is kind of an ongoing step that appears in every Phase – is sort of never done – you just keep trying to improve it more and more as

time goes on. The coding staff should continue to increase familiarity with the ICD-10 code sets, and education on the biomedical sciences and pharmacologies should continue to be provided as identified during the knowledge gap analysis that was done during Phase 1.

Continue to regularly follow up on the readiness status of business associates. Refine the project, a timeline and budget as needed as you go along and as you learn more about the steps and the process and the costs. And also in Phase 2 start developing a contingency plan for continuing operations if critical systems issues or other problems occur when ICD-10 implementation goes live.

Now some of the consequences of not planning well for ICD-10 include things such as increased claims rejections and denials, increased delays in processing authorizations and reimbursement claims, improper claims payment coding backlogs, compliance issues, end decisions based on inaccurate data. But many of these potential problems, in fact all of the potential problems can really be mitigated through proper planning and preparations.

On slide 59 I've just given you some examples of some of the resources that are available on the AHIMA ICD-10 Web page. Many of these resources are free. One of – a couple of the key things on there is the ICD-10 Preparation Checklist which these phases are based on that I just described. And that checklist is actually currently undergoing a revision and the revision should be posted soon.

There are also role-based implementation models for different categories of people including inpatient and outpatient coders, data managers, academic educators and students as well as payers that provide a timeline over the next several years for key tasks for those groups, and there are more role-based implementation models being developed. But those are also freely available.

And now I would like to turn the presentation back to Pat.

Leah Nguyen: OK, thank you Sue. We have now completed the presentation portion of this call. And we'll move on to the question and answer session. Before we begin I would like to remind everyone that this call is being recorded and transcribed. Before asking a question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one.

And also at this time we did want to remind anyone who may have joined us late that we do have continuing education credits that may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS national provider teleconferences. Please see slides 61 and 62 of the slide presentation for more details.

All right Shannon, at this time you may open the lines for questions.

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 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 back ground noise will be heard in the conference.

Your first question comes from the line of Sue Kelly. Your line is now open.

Sue Kelly: Hello, can you hear me?

Sue Bowman: Yes.

Sue Kelly: Our question is we are a long – this is Westbury United Methodist Community in Meadville, Pennsylvania. We are a continuing care community and for the transition for ICD-10 from ICD-9, will it be necessary to do a full change of all of our codes in our system to be prepared for the October deadlines that all codes are ICD-10?

Pat Brooks: This is Pat Brooks. I think if what you're asking is should you go back and recode all of your old data and all of your old claims, the answer would be no.

Sue Kelly: Current diagnosis coding.

Pat Brooks: That's correct. For right now you'll continue coding with ICD-9-CM. What you will do, the action you will take with ICD-10 is beginning for care provided on October 1, 2013. At that point you'll be coding with ICD-10 and no longer using ICD-9. You do not have to go back and recode from times before that. Is that your question?

Sue Kelly: Well our diagnoses are continuous because this is long term care. Do we need to update all our codes because they're all being used in current care, to ICD-10?

Pat Brooks: If what your questions is, if your claims cross the implementation dates, we have not developed an agency position now on how we will instruct people whose claims span the implementation date. But we will be announcing something in the future if that's the nature of your question.

Sue Kelly: I think so. Thank you.

Pat Brooks: Thank you.

Operator: Your next question comes from the line of Anne Dodro. Your line is now open.

Anne Dodro: Thank you. I'm calling from Dr. Gregory Weatherford's office. I'm sorry at the very beginning of the conference you told us where we could find the slide show and I missed that. I'd like to go back there and maybe copy that down.

Leah Nguyen: OK, what you would do is go to the ICD-10 Website at www.cms.gov/icd10, and on the left hand side you would click on the tabs for CMS Sponsored ICD-10 Teleconferences. And then, from that page you'll see like a table with a list of all the conferences. And you would just go ahead and select the January 12, 2011, call. And from that page once you're on the call page you

scroll down to the bottom and the presentation is under the Downloads section and the article is under Related Links Inside CMS.

Sue Kelly: Thank you.

Operator: Your next question comes from the line of Sue Thelman. Your line is now open.

Sue Thelman: Hi there, just a quick question in the beginning part of the show, slide show it's partial code freeze. Can you go over that just a little bit more? We're still a little confused on that.

Pat Brooks: Yes, this is Pat Brooks. I'd be happy to do so. It might help you to also review the other document that we posted in addition to the slide presentation was the MLN Matters information that's more clear. But basically it will work like this, each year now there are updates to ICD-9-CM codes, maybe two or three hundred a year. Many people feel like 200 to 300 a year code updates is hard when you go through all the steps that Sue Bowman talks about preparing for ICD-10.

That's a lot to consider when you're updating your systems and payments each year for code updates. So we want to reduce the number of code updates. So basically what's going to happen is that on October 1, 2011, we'll have the last regular updates to ICD-9 and ICD-10 so you can anticipate the usual rather large number of code updates at that time.

After that we will be ratcheting down the number of codes that are updated each year, significantly ratcheting them down so that the only new codes you see on October 1, 2012, are those that would capture what is clearly some type of a new technology or a new disease, the H1N1, something like that.

On October 1, 2013, we will have the same number, a very small number of code updates. Clearly that's the date that ICD-10 starts and there is the possibility that the day it starts we will be adding a few new codes for new technology and new diseases on the day ICD-10 begins.

Then again on October 1, 2014, the public will be able to ask for any needed code updates they want. And there's a possibility of the normal, rather large updates to ICD-10 codes in 2014. ICD-9 will not be updated on October 1, 2013, because it'll no longer be in effect.

So what you can anticipate is business as usual through this October 1, 2011, with large code updates. And then a freeze, which will greatly reduce the number of updates in the following years, does that help?

Sue Thelman: Yes, thank you very much.

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

Joy Haywood: Thank you, my name is Joy Haywood. I work with Montgomery County Health Department. And we have just converted to the HIS system. And I just would like to know if these codes are going to be rolled over into that system or is somebody from Raleigh going to have to key each one of these codes in?

Pat Brooks: I would say that – and I'm not familiar with your system but that's one of the things that Sue might want to address how she would tell you to ask about that system. Sue, did you want to go through that part of your slide presentation?

Sue Bowman: Yes, I would refer you to the slide about talking to your vendors. You know a lot of the vendors are going to provide an upgrade to your system for ICD-10. So you might want to talk to your vendor about when – if they're going to do that - when they plan to have that ready. And issues like is the cost going to be part of their routine maintenance contract or are they going to charge separately for making that upgrade.

Joy Haywood: OK, thank you, ma'am.

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

Lisa: Hi, this is Lisa calling from the University of Rochester Medical Center in Rochester, New York. My question is who do you recommend in your facility to establish the steering committee? And also to head up the impact assessment? Is it the responsibility of the HIMSS department or is it the responsibility of compliance? Who is the best person to head up this steering committee?

Sue Bowman: This is Sue and I'll take that question. It kind of varies depending on the structure of your organization and roles and responsibilities. In many organizations it is someone from HIM who has headed that up. And then put the steering committee together with people from IT, someone from – I urge you to include somebody from the medical staff to have that linkage with the physician and business office manager.

Key people that are going to be significantly affected by the transition should be on the committee. But it may depend internally on how your organization works, who is the best person to lead that. In many cases it may be an HIM person.

Lisa: Would compliance be able to lead such a committee? Would that be recommended or is it preferred that HIMSS do that?

Sue Bowman: It's possible Compliance could do it. It's best if someone who and it sort of depends what the – I guess what the background and knowledge of the person in a particular position is - but it is helpful if the person who leads the steering committee has some knowledge about the code sets and what's involved with the process because that's sort ensures that it gets off on the right foot, that its got the right time and resources associated with it because someone is estimating accurately what this all entails.

Lisa: OK and I also have another question. Do you recommend that facilities send people to have – be certified trainers and have training done within? Or is it perhaps better to have your training outsourced?

Sue Bowman: That really depends on your own organization and whether you want to have – I don't know how many people, how many coders you have to train.

Sometimes if you have a large number of coders to train, it's easier logistically, cost-wise and so forth to have one person become a trainer to come back and train everybody in your organization.

Sometimes people prefer to actually send their coders somewhere to be trained by somebody else. It really depends on the size of your organization, how many people you have. You know where you're located. What kinds of travel costs there might be in sending people somewhere else versus having the training done internally.

That's all part of what really needs to be discussed through this whole Phase 1 process moving forward is how do you normally do training for new projects and new initiatives. And what will work best given the size and structure and number of people in your organization.

Lisa: OK that's great, thank you very much.

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

Cindy Schuster: Hi, my question is that right now we don't get coding books in our facility. Well we do for the clinic but not for medical records because we use an encoder online. And do you recommend that we would get the ICD-10 code book or continue to go with just what's online.

Sue Bowman: If you are used to using electronic coding tools you know I would say it's fine to continue that. As a matter of fact, ICD-10 is even more amenable to electronic coding than ICD-9 is. So there's no reason to buy a book just because you're moving to ICD-10. You'll be able to do the same things with an encoder. So I would say just continue with the encoder products.

Cindy Schuster: OK and then that would also give us the – like the code sets you know like right now if you have diabetes and renal failure, you end up with two codes. It would also do that for ICD-10, is that correct?

Sue Bowman: Right, I mean you could – again you could talk to your encoder vendor exactly about their transition process of converting their product. But I

assume that whoever your vendor is, they would convert it to be just as strong of an encoding product if they have for 9.

So if it requires two codes to complete a diagnostic statement or there's instructional notes saying you need another code from over here to go with that you know all of those kinds of pieces of the coding system would still be part of your encoding product – that they would upgrade the product to do the same sort of coding, only with ICD-10 and the ICD-10 rules.

Cindy Shuster: OK. Thank you.

Operator: Your next question comes from the line of Patrice Ostro. Your line is now open.

Patrice Ostro: Good afternoon and thank you for the presentation. My question is, as this conference relates to billing for Medicare and Medicaid services, have you been informed from the other major carriers across the country that they're going to also be on board with usage of ICD-10 codes at the same time that Medicare and Medicaid services will be implementing?

Pat Brooks: This is Pat Brooks and, yes – they have some standards that require Medicare and Medicaid to go to ICD-10 – also mandates that all others using these electronic billing formats have to go, and the compliance date is dictated in the regulations. So you should assume that your other payers – your Blue Crosses – your – whoever – as a matter fact, many of them may even be on the phone now – they have been working very hard to convert their payment system, so that they can receive the codes at the same time that we do.

Patrice Osto: OK – I know we're limited to one question, but I do have one quick one – do you have any word on workman's comp?

Pat Brooks: No – we do not have any word on workman's comp, but I believe that a different part of our agency is working on that – they are working with them – and perhaps we will have some statements later.

Patrice Osto: OK – great – thank you.

Operator: Your next question comes from the line of Noona Seese. Your line is now open.

Noona Seese: Thank you. We are an outpatient behavioral health organization, and I know most of the questions have been to the physical health part of it – could you give me a brief update on what mental health has to look forward to? I understand the CPT codes will stay the same, and we currently use DSM codes – could you please talk in a little bit more detail about mental health?

Pat Brooks: Sue, do you want to go through the comparable DSM mental health tester issues?

Sue Bowman: Well, do you use – do you use ICD-9 codes for billing, though – at all?

Noona Seese: Some of them – yes.

Sue Bowman: Because just as in ICD-9, there is a mental health chapter in ICD-10-CM – it's actually more robust and more in line with the DSM-IV codes because the American Psychiatric Association has been very involved with the development of that chapter of ICD-10-CM. So wherever you were using ICD-9-CM mental health codes before, you will be converting to ICD-10-CM mental health codes.

Noona Seese: And when we're using the DSMs, will we still be using the DSM-IV codes?

Sue Bowman: I'm not sure exactly where you're using them, but yes, DSM-IV, DSM, and the purposes that DSM is used for, is not going away. If you can think of it as, wherever ICD-9 is being used, it will be replaced by ICD-10. Where a different code set was being used, that would not be affected.

Noona Seese: OK – so if we're using the DSMs, we should be OK, then?

Sue Bowman: Where you're using the DSMs – yes. But if you are – it sounded like you are using some ICD-9 codes – that's where you would be changing to the ICD-10 codes.

Noona Seese: OK.

Pat Brooks: And let me make one small point. Many people use DSMs to look up codes, and the code numbers look like the current ICD-9-CM mental health codes. The numbers are almost identical, if not identical. When ICD-10 comes along, you will have to use an ICD-10 code.

I believe that DSM is going to a comparable look – they were suggesting we move our update up, but HIPAA will not allow it, but I believe by the time that works out, more than likely the DSM entities – code numbers will look just like the ICD-10-CM codes. But for billing purposes, the numbers you sent in – they have to be ICD-10-CM.

Noona Seese: OK. OK – all right – thank you so much for your help.

Operator: Your next question comes from the line of Eudela Lane. Your line is now open.

Eudela Lane: Hi – yes – my question is – who do we contact for training – someone that would come into the facility, or do we need to go out to seminars – or who's going to train us on ICD-9 coding? I'm calling from – in Loudoun Nursing and Rehab Center in Leesburg, Virginia.

Sue Bowman: Well, this is Sue Bowman. Other – there are actually a lot of organizations that are doing training for trainers – as I mentioned earlier, it's not really the time to have intensive training for coders except to …

Eudela Lane: Right.

Sue Bowman: … send them to presentations to kind of learn what's going to happen and that kind of thing, but I know that AHIMA, for example – we have academies for training trainers – I believe there are other organizations, as well, that are providing training programs.

Eudela Lane: Are – is there something I can get off line?

Pat Brooks: This is Pat Brooks – that's why we've supplied you with the WEDI enhanced locations – the slide – let me find that number for you.

Eudela Lane: OK. So this is a number I can call for training?

Pat Brooks: The WEDI and HIMSS slide is the one that lists – yes – slide 28 – and I assume AHIMA even has their self listed there – any organization that has ICD-10 resources, like software, training, whatever – they can sort of self request that WEDI and HIMSS list their products. So you can browse those two websites and see if you see something close by, convenient, or whatever that suits you.

Eudela Lane: OK – what are the websites?

Pat Brooks: On 28 of the handout – it's for WEDI – WEDI and HIMSS – HIMSS. We at CMS can't endorse one group or the other, but we did arrange for these two organizations to allow other organizations to post availability of resources since people like yourself would like a place to look for what's available.

Eudela Lane: OK – So I need to go on the CMS Website and go to the slide number 28 – you're saying?

Pat Brooks: Yes – did you not print out the slides for this call? It's the slides for this call.

Eudela Lane: No I didn't – I didn't.

Pat Brooks: OK – then you do that and look at slide 28.

Eudela Lane: OK – so I need to go on the website to the CMS Sponsored ICD-9 teleconference?

Pat Brooks: Yes – Leah will give you directions for doing that again – yes.

Eudela Lane: OK.

Leah Nguyen: What you do is, you can go to the CMS ICD-10 Website at www.cms.gov/icd10.

Eudela Lane: Yes.

Leah Nguyen: And then, over on the left-hand side, click on CMS Sponsored ICD-10 Teleconferences.

Eudela Lane: Yes.

Leah Nguyen: And from there you'll see a chart of all the calls that we've held, and you want to select today – the January 12, 2011 – and then scroll down to the bottom, and you'll see the slide presentation under the download section.

Eudela Lane: OK. And I just go to slide 28?

Leah Nguyen: Yes.

Eudela Lane: All right – thank you.

Leah Nguyen: You're welcome.

Eudela Lane: Yes – bye-bye.

Operator: Your next question comes from the line of Brandy Enright. Your line is now open.

Brandy Enright: Are physicians to inpatients – see patients – that are inpatients in the hospital, and I just want to confirm that we can continue using the HCPCS codes that we have now.

Pat Brooks: That is absolutely correct. We tried to make that just as clear as we could on slide five –and slide six – where we say ICD-10-PCS will not be used on physician claims even those – the physician claims for inpatient visits. So that's on slide five – and on slide six – there'll be no impact on CPT or HCPCS, so everywhere you're recording CPT or HCPCS now, you'll continue doing that, even after ICD-10 is implemented.

Brandy Enright: Thank you so much.

Operator: Your next question comes from the line of Dana Koffman. Your line is now open.

Dana Koffman: Yes, this is Dana Koffman from Healthcare Computer Corporation, and I have a question regarding – when – or has anything been determined about how to handle items that have a span date that will cross the timeline of 10/1/2013?

Pat Brooks: No – I told one of the previous questioners – the issue of span of service that crosses the October 1st implementation date – we do not have a CMS position to release yet. Hopefully, on one of the future calls, or in definitely, this information would be released formally, once it's decided, but at this point in time, those that span the service – spans the implementation date – we do not have any agency position on that yet – and it may be that different payers will handle it differently.

Dana Koffman: And have they posted any updates on when they're going to start revising the Medicare LCDs and the CMNs?

Pat Brooks: I can just tell you that when we're for – first out of the gate to an MS-DRGs, we get a lot of work at other parts of the agency, including those working on the NCDs and LCDs – are actively working on that. We don't have anything to share with you now about when that will be completed and when that will be shared, but there are a lot of efforts on the way on that activity within CMS.

Dana Koffman: OK. That sounds good – thank you.

Operator: Your next question comes from the line of Louann Hitener. Your line is now open.

Louann Hitener: Yes – hi – thank you. My question is, some of your documentation there states that the ICD-10 will affect scheduling and registration, and I'm just wondering how that impacts them?

Sue Bowman: This is Sue. In some cases – in some departments or some facilities – the registration area uses the codes to determine coverage issues and medical necessity requirements and that sort of thing. So that's an example of an area where there might be codes being used that you don't even know about.

Louann Hitener: Thank you very much.

Question and Answer Session Continued

Operator: Your next question comes from the line of Gail Whaley. Your line is now open.

Gail Whaley: Hello – this is Gail Whaley from St. John Medical Center in Tulsa, Oklahoma. We had a question about – referring to state registries – can the states require us to still continue to use ICD-9 codes after 2013, or will they allow us to use the new codes?

Pat Brooks: That I don't know. Sue, are you aware of that?

Sue Bowman: I'm not aware of anyone who is planning to continue to use ICD-9 codes. I'm aware of a lot of activities from registries and performance measures and so on that they're involved in transitioning to ICD-10. While they may not be some of these registries and so forth aren't covered HIPAA entities, the fact is that, as Pat mentioned, ICD-9 will no longer be maintained. Ultimately, you won't even, I imagine, be able to buy an ICD-9 book or an ICD-9 product. So it really doesn't behoove anyone to continue to use the ICD-9 codes, particularly in areas such as registries where the quality of the data is so critically important.

So I guess my answer to that is I have not heard of anyone who was planning not to move to ICD-10 for that type of data.

Gail Whaley: Great, thank you very much.

Operator: Your next question comes from the line of Clare Capello. Your line is now open.

Clare Capello: Yes, hi.

I'm wondering if you could talk about the paper claims. Do you think it's actually possible that come October 1, 2013, some hospitals will be billing paper with I-9 and electronic with I-10?

Pat Brooks: This is Pat Brooks. I can tell you for Medicare purposes if they do that they wouldn't get paid because our logic is converting to ICD-10. So our inpatient and outpatient payment logic would not work at all if an ICD-9 code came through there.

Clare Capello: So even though it's not HIPPA mandated it would be payer mandated?

Pat Brooks: If it's just like what Sue says, ICD-9 would not be maintained. It's a – will not be – they won't have code books for that. With people changing to ICD-10, simply because you use a paper claim I think you should not expect your local – your non-Medicare, your private insurer to decide to set up dual systems to pay you. I think you should expect that you'll have to convert your paper claims. You'll start to have to learn to use ICD-10 codes and put those on your paper claims, too.

Clare Capello: Well, I hope you're right. Thank you.

Operator: Your next question comes from the line of Rowena Rojos. Your line – I apologize – the line of Steven Palmore, your line is now open.

Dr. Kelly Butler: Hello, this is Hello Medical Center. This is Dr. Kelly Butler with Health Information Resource Group.

I'm going to be the cynic. I worked with coding for well over 30 years and the documentation. I am preparing to go with I-10, but we get messages from different of our vendors and payers that there is a possibility that 2013 date is not going to happen.

We're really worried about putting a lot of time and expense and preparation into something that might not happen or be delayed that will cause us additional expense and resources.

How rigid is that 2013 date so that we can proceed – and again I say this because of working 30 years with coding, every two to five years there's been this message of, oh get ready, ICD-9 – ICD-10 is going to happen in two to five years.

Pat Brooks: Well, let me just say this. We have talked about the possibility of that happening, but what's different now is we actually have that final rule that went out. And CMS versus other payers are actively converting their payment and internal systems to get ready for ICD-10. They're going to have payment systems ready to go live on October 1, 2013. To turn that back would be quite difficult.

The message we're giving you strongly is that we're spending a lot of internal time here at CMS doing just what Sue Bowman just said. We're doing implementation, planning. We're converting our systems. We are doing payment policy updates, and I think you and the provider community should do equally. You should get ready and assume we're serious because that's what we're doing. You should get ready and move forward.

Dr. Kelly Butler: Thank you.

Operator: Your next question comes from the line of Val Thompson. If your line is on mute, will you please unmute your line.

Your next question comes from the line of Mary Vio. Your line is now open.

Mary Vio: Yes hi, my name is Mary Vio, and I'm calling from Monarch HealthCare in Irvine, California. My question pertains to the GEMs. Can you tell me how the CMS file differs from those being offered by various vendors?

Pat Brooks: This is Pat Brooks. You know that's a question like Sue says that you may want to do your own planning for. I would assume, but I do not know that the other vendors have taken all of the work that CMS did cause picked up the logic of the GEMs on our website. We did that. Anyone can take that for free. They can take that logic, and they can automate it.

How the bells and whistles work, how the automation would vary from one to the other I would assume that no vendor decided they disagreed with our GEM logic and changed it, but that is a question certainly if you were concerned about it then, then you could ask them. Does this work based on the official, annually updated GEM style based on CMS' website? If they say

yes then you know this is exactly what you have. If it doesn't then you might investigate what they have and to see if it's something you want to use.

Mary Vio: OK, thank you.

Pat Brooks: Sue, do you have anything else more to add about vendor evaluations?

Sue Bowman: Yes, one thing I would add is I do, I agree with you Pat. I do use one of the vendor provided mapping – products. And it's exactly what you said. They have just automated the GEMs similar to taking the code set and creating and encoder from it where nobody has changed the codes or done anything different with the code, but they might have made it more user friendly.

Added some bells and whistles to find things, but it's still the basic code set. That too is my understanding of what the vendor GEM products are, but it is a good question to ask your vendor just to make sure that that's what it is.

Mary Vio: OK, thank you.

Operator: Your next question comes from the line of Sherry Kennedy. Your line is now open.

Sherry Kennedy: Yes, this is Sherry Kennedy with Knowledge Solutions in Bevins, Texas, and my question, first of all, will more specific information as to implementation for nursing home providers be provided by CMS, and if so, when can that be expected?

Pat Brooks: This is Pat Brooks. I'll just answer you generically as I did earlier. All the payment policy updates are in the work now, and those that have regular means of updating their policies like formal rule making, the year we moved out to ICD-10, you can expect that ICD-10 will be part of that rule making.

They may actually, like we have on the end patient side, post some of our draft work early so you can see how we're converting our payment logic to let you know in advance. But all the CMS payment policy will go through its usual formal rule making.

Sherry Kennedy: All right thank you, and then you talked about increased documentation specificity. A requirement for that with the ICD-10 coding, and where can I find resources on that?

Pat Brooks: I'm not sure I understand the question. Sue, do you?

Sue Bowman: Could you repeat the question?

Sherry Kennedy: Certainly. Where can I find resources that would meet the requirements for increased documentation specificity?

Sue Bowman: Well there is – I'm trying to think how to answer the questions because it sort of depends on your documentation. What I have suggested doing is, saying for example, take your top diagnoses, your top 25 diagnoses, and pull a random sample of records or a certain sample by physician, and then analyze it against the ICD-10 codes for those diagnoses would be a way of starting to look at that. Sort of just do a random check. See how the documentation matches up in your facility in some of the common cases. Is that the kind of thing you were referring to?

Sherry Kennedy: It is. It is. I didn't know if there was a resource out there that would say specific, if you were using this code, this is the type of documentation that would be required.

Pat Brooks: You know, I think the presentation that Sue Bowman helped us do on the ICD-10-CM basics, I think that may just be something you might want to look at because Sue pointed out some areas where ICD-10-CM changed. And being aware of that, like adding in left and right, things like that...

Sherry Kennedy: Yes.

Pat Brooks: … where, some issues that she may want to review your documentation for. Wouldn't you say Sue that you covered a lot of very good basic parts to the changes with ICD-10-CM? I think that was the…

Sue Bowman: Yes, during that presentation we did cover a number of examples showing how the codes are different in ICD-9 and ICD-10 and where there's greater

specificity that would be a good place to start looking for areas that you can look at your documentation in. So yes that would be a good resource.

Pat Brooks: That call was March 23, 2010. It was called Basic Introduction to ICD-9-CM National Provider Call.

Sue Bowman: There's also, a number of organizations have put out resources and ICD-10 books and workbooks showing some of the differences between the code sets. That would be another resource you could possibly look to as well, but I think that's where the knowledge that I talked about, in gaining familiarity from the coding staff of what some of the differences are.

Because then it makes it easier to do some kind of assessment of a sample of records if you have a basic understanding of some of the areas if there's increased specificity either in the type of disease or in the anatomic site for example.

Sherry Kennedy: Excellent. Excellent. Thank you very much.

Operator: Your next question comes from the line of Stacy Barnes. Your line is now open.

Stacy Barnes: Yes, hello. My name is Stacy Barnes. I'm calling from an OB/GYN practice, and I'm just a little confused. I know one of the previous callers had a similar question. It was regarding the ICD-10-PCS. Now we're a doctor's office. Our doctors do go to the hospital to deliver babies, do consults, surgeries. Some are inpatient, some are outpatient. So basically what my question is, do we have to use the ICD-10-PCS or do we still use the regular CPT codes?

Pat Brooks: Yes, this is Pat Brooks again, and the answer to you is, you do not have to use ICD-10-PCS. On slides five and six, what we tried to say is that the only people using ICD-10-PCS will be hospital personnel who are coding hospital claims.

Stacy Barnes: OK.

Pat Brooks: You're coding a physician claim. You use CPT and HCPCs, and as we show on slide six, everything you do with CPT and HCPCs now, you'll be doing when ICD-10 comes out. The only difference you'll see on your claims is that you will be capturing diagnoses using ICD-10-CM. You will not be using ICD-10-PCS.

Stacy Barnes: OK. OK, that clarified everything. Thank you so much.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Chmiel Moore. Your line is now open.

John Spencer: Hello, this is John Spencer actually, speaking on behalf of Chmiel from Inter Mountain HealthCare. We just had a question. We're working on how to deal with the dual processing issue. We're a provider, and it sounds like we need to be able to send ICD-9 codes to non-covered entities indefinitely, and rebuild for up to seven years, and maybe even payers that don't make the deadline, but we still need to get paid.

It also seems that our internal and external reporting stakeholders will need some kind of continuity over this reporting transition. We're exploring the using the GEMs to try to crosswalk that data to build this blended picture, but we wondered if you had any suggestions or recommendations on how to approach this challenge.

Pat Brooks: The only thing that I can suggest to you is for the inpatient because that's where I work, is that we realize we'll be processing dual claims too, dual coded claims as the ICD-9s come in late for an inpatient claim maybe then you would have expected earlier. We will be going on date of service to determine if the provider should have put down ICD-10 or ICD-9 code, and our logic will be built on date of service.

That's all that I can share with you what we're doing on the inpatient side. Other parts of CMS are working on this problem of dual processing, but it may take different nuances for different people. Perhaps it helps knowing if

you focused heavily on the date of service and keying up your own processing logic, that might help.

John Spencer: I think the challenge we were trying to figure out with the reporting. How do we build this picture – because of how the requirements have been set up for the CMS change, it really will be dual processing for a long time so we're just trying to figure out how do we build reports that will be able to hit both 9's and 10's.

Pat Brooks: Yes, and I wish I could share more, but I think that's – as you learn more too, maybe in some of the future calls as you've worked these issues out, perhaps you can share that during the open part of the meeting. Thank you.

John Spencer: Thank you very much.

Operator: Your next question comes from the line of Val Thompson. Your line is now open.

Lucia Beeler: Hello, can you hear me?

Pat Brooks: Yes I can.

Lucia Beeler: This is Lucia Beeler from VF Christie Health Systems in Wichita, Kansas, and we wondered if you could describe how CMS is implementing the ICD-10 into their own initiatives like PQRI, core measures, medical necessity, and when we might be getting communication about those.

Pat Brooks: Well as I said earlier, all those parts, and many other parts of CMS are actively having discussions and meetings, just like Sue mentioned – we're having internal implementation meetings to discuss how best to convert all those, and the timelines of how to roll them out. We don't have anything firm to announce on that, but we're doing exactly what Sue laid out for us. And, as things are finalized, they'll be – you'll be notified in the usual process for updates.

Lucia Beeler: Very good – thank you.

Operator: Your next question comes from the line of Matt Santegelo. Your line is now open.

Matt Santangelo: Hi – that's Matt Santangelo from First Atlantic Health Care. Will Medicare reimbursement be affected or delayed in any way during the transition?

Pat Brooks: We planned no delays – no grace periods – we are working at least – and I'm – once again, I have to apologize – I'm in the inpatient area – we're working on converting our MS-DRGs so its data driven so there would not be delays. Just like now – when we convert several hundred new codes each year at MS-DRG – date driven on October 1 – the claims come in like that – and we've been successful in handling those.

And we hope that all the parts of CMS will have their payment logic finished, and so that, hopefully there won't be anything more of the small hiccups, or whatever. But we do plan to convert – not to have claims come in and have to map back with the GEMs to a different coding system. I don't know if that helps.

Matt Santangelo: Thank you.

Operator: Your next question comes from the line of Monique Riggins. Your line is now open.

Monique Riggins: Hi – this is Monique Riggins calling from Independence Blue Cross, and I was wondering, since the ICD-10 diagnosis codes are so specific, including things such as left and right, will there be edits in place, or is it recommended that payers put edits in place when an LT modifier or RT modifier is submitted on a HCPCS code, but the diagnosis code is actually contradictory?

Pat Brooks: You know that would be something that hasn't been worked out yet – as we've discussed, we're converting – we're analyzing how we're going to convert our local coverage decisions and our national coverage decisions, but the extra specificity in ICD-10 allows for just what you mentioned.

Right now, if you feel like something is done twice – a fractured arm's reported twice on different dates – sometimes you have to get additional

information to verify that they really meant that this is two different extremities and not a repeat. With ICD-10, perhaps some of those things will flow through the system better.

And perhaps, some payers – contractors – will want to take the extra specificity and do edits, just like you mentioned, but I don't think anyone has finalized all those details of edits yet, since we're at the point now where we're doing the implementation planning and looking at how we're going to convert our internal edits and our payment systems using the greater detail in these codes.

Monique Riggins: OK. And – second part of that – are the – is the AMA looking at actually revising the CPT codes that – along with the modifiers – in anticipation of ICD-10?

Pat Brooks: You know I can't really speak to them – you would probably have to ask them about the CPT efforts – I'm not on the panel.

Monique Riggins: OK. Thank you.

Operator: Your next question comes from the line of Ted Mycinski. Your line is now open.

Ted Mycinski: Yes – I'm wondering if CMS is planning to publish revisions to the MS-DRGs soon?

Pat Brooks: Well, you know right now we have version 26 of the MS-DRGs and ICD-10 codes – at the September 2010 ICD-9 Coordination and Maintenance Committee, we informed everyone that we were right in the middle of developing version 28 – that matches the current version that we're using in Medicare. We will be posting those files – the version 28 – for fiscal year 2011 on our website in March. And we will welcome anybody to review and comment on that latest update to ICD-10 MS-DRG.

Ted Mycinski: Thank you.

Operator: Your next question comes from the line of Sue Donahue. Your line is now open.

Sue Donahue: Hello. I think one of the previous questions answered my question, which was – what would be the timeline for using ICD-10-PCS codes in an outpatient setting?

Pat Brooks: Well, ICD-10-PCS codes will not be used in outpatients ever they're only …

Sue Donahue: Ever?

Pat Brooks: Ever. The ICD-10-PCS will only be used on inpatients – for inpatient claims, and they'll be used for inpatient claims starting October 1, 2013. Outpatient parts of the hospital now use CPT and HCPCS, and they will continue to do so. And that's clarified in slide six. So ambulatory services, which a hospital outpatient department is, uses CPT and HCPCS now – they will continue to do so. The only, very small group that's moving to ICD-10-PCS is hospital inpatient claims on a hospital claim.

Sue Donahue: So, there's no plans whatsoever to move to any 10 coding in outpatient procedure?

Pat Brooks: ICD-10-CMs diagnoses will be used in outpatients – yes. But the procedure code – ICD-10-PCS – no – it will …

Sue Donahue: OK.

Pat Brooks: … not be used in outpatients.

Sue Donahue: I just wondered why, you know.

Pat Brooks: That was part of the HIPAA process with formal rule making. We had comments on all that …

Sue Donahue: Yes.

Pat Brooks: … and that's basically the way it worked out.

Sue Donahue: OK – thank you.

Leah Nguyen: OK, Shannon, I think we have time for just one final question.

Operator: Your final question comes from the line of Kalima Jackson. Your line is now open.

Kalima Jackson: Yes, hi, my name is Kalima Jackson. I'm calling from Patient Services in Arlington, New Jersey. Once the CMS ICD-9, I'm sorry – ICD-10 codes are active, are they – well, will they be able to print on the current CMS claim form?

Pat Brooks: If you're talking about the paper claim – can already hold along the digits, and if you're asking about – will the 4010 format for reporting electronically claims, it will not hold an ICD-10 code – that's why we've had this big internal movement to the 5010. Those two previous conference calls that I spoke of earlier …

Kalima Jackson: Yes.

Pat Brooks: … talked about how our systems are being changed so that your system – that you modified to go along with it – will be able to hold those longer codes that have more alpha characters. And if you want to learn more about that, then you need to listen to the June 15th and September 13, 2010, outreach calls.

Kalima Jackson: OK. OK, thank you.

Leah Nguyen: Unfortunately, that is all the time we have for questions today. Don't forget you can still e-mail your questions to ICD10-National-Calls@cms.hhs.gov. This e-mail address is also listed on slide 63. Also, please note that continuing education credits may be awarded by the American Academy for Professional Coders or the American Health Information Management Association for participation in CMS national provider teleconferences.

Please see slides 61 and 62 of the slide presentation for more details. Oh, right. Please contact these organizations directly to help you, rather than

CMS. We would like to thank everyone for participating in Preparing for ICD-10 Implementation in 2011 National Provider Teleconference.

An audio-recording and written transcript of today's call will be posted to the CMS Sponsored ICD-10 Teleconferences section of the CMS ICD-10 Web page at www.cms.gov/icd10 in approximately one to two weeks. I would like to thank Pat Brooks and Sue Bowman for their participation. Have a great day, everyone.

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

END