Centers for Medicare & Medicaid Services
ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks) National Provider Conference Call
Moderator: Ann Palmer
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Christine: Good afternoon and welcome to the ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks) 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. I will now turn the conference call over Ms. Palmer. Ma'am, you may begin.

Ann Palmer: Thank you and, as Christine said, I'm Ann Palmer and I'll be moderating today's conference call. The written and oral transcripts of this call will be posted in a few weeks on our website. You can find call transcripts and discussion materials for this conference call by selecting 2009 CMS Sponsored Calls on the left side of the ICD-10 Web page, which is located at www.cms.hhs.gov/icd10. Our speaker today is Pat Brooks who is Senior Technical Advisor at CMS. Go ahead, Pat.

Pat Brooks: Thank you very much, Ann. Today we're going to be talking about ICD-10 and this is the latest in a series of outreach calls we've had on ICD-10. We'll be doing - I'll be providing - a brief overview of the ICD-10 Final Rule and some of the requirements of that final rule. I'll be discussing differences between the ICD-9-CM coding system and ICD-10. And then I'll be turning most of the presentation - I'll be focusing on

the mapping overviews - the General Equivalence Mappings, the tools that we've developed to help convert data from ICD-9 to ICD-10. Hopefully, after I finish this you'll understand what the GEMs are, who should use them, where you can find the GEMs in the User Guide, and how to use the GEMs. There was a great deal of interest in this topic today. I understand we had about 6,000 people registered. So, hopefully, after this call you will all better understand how to use the GEMs.

If you'll turn to your third slide we'll discuss the ICD-10 Final Rule. The final rule was published on January 16, 2009. The rule gave an implementation date for ICD-10 of October 1, 2013 - and that's the date at which providers will be using and coding with ICD-10-CM for diagnosis and ICD-10-PCS for procedures for inpatient systems. One important point to mention is that this final rule implementing ICD-10 has no effect at all on reporting with CPT and HCPCS codes. Providers who use CPT and HCPCS codes now will continue to use them even after the implementation of ICD-10. For those of you who would like to read the final rule - and it’s not that long, it’s only about 33 pages - we've provided on slide 3 a link to the full ICD-10 Final Rule.

Slide 4 goes through some major issues discussed in the final rule. And a very important one is that there's going to be a single implementation date for all users - as mentioned earlier - that's October 1, 2013. And that will be for date of services - in other words - any patient that walks into an ambulatory care or physician office on October 1, 2013, beginning with that date for those encounters, you will begin coding and reporting ICD-10-CM Diagnosis Codes. For discharges for inpatients - beginning on October 1, 2013 discharges - hospitals will begin using ICD-10-CM for diagnosis and ICD-10

Procedure Coding System, PCS, for procedure reporting. We anticipate - and - there will be no delays in this implementation date. Unfortunately, I believe some speakers in the industry talk about maybe this being delayed, or postponed, or double coding but let me make very, very clear to you that HIPAA Final Rule states that this is a firm implementation date of October 1, 2013 for implementing ICD-10. As a matter of fact, with the edit setup for Medicare and other insurers, too, I imagine ICD-9 codes will not be accepted for services provided on or after October 1, 2013. So if you were to choose the wrong coding system after that time, these claims could be returned so that you would have to put down the correct code. So now is the time to prepare and think about this implementation date. Obviously, after the implementation date, we'll have claims that will continue to flow through various payer systems. As with today, there'll be ICD-9 claims we're processing that are for services occurring before the implementation date. So we know that there will be a period of time where dual codes will be received. However, you need to use the next four and one-half years to get ready to make a switch in your facility to use the ICD-10 codes.

Slide 5 discusses some issues that we discussed in our final rule. CMS said that we would be doing outreach and education, and we've been very busy with that. This is one of the continuing series of outreach calls that we've had. CMS has also worked collaboratively with some of the other Cooperating Parties for ICD-9 and ICD-10 and that includes the American Hospital Association, the American Health Information Management Association, and CDC. We've worked together to develop some of the products that you'll find on our web pages, and also to do some of the prior educational outreach calls. I've provided two web links for you. The first one - for Educational Resources - if you

click on that you can see some very basic and good overviews of ICD-10 itself - a fact sheet. We also have some fact sheets on use of the GEMs - the mappings that we're discussing today. After this if you want to look at those in more detail and perhaps use some of those outreach documents to educate other people on your staff - that would be very good. Others have mentioned they were not able to participate in earlier calls. If you click on that link on the bottom of page 5 for Sponsored Calls, you'll see that we have calls from 2008. We have now posted the audios of those calls, written transcripts, and slides. The information presented in those 2008 outreach calls are still relevant. So those of you who missed them, who want to listen to them - you can do that at your convenience. You can open those up and listen to them. And as Ann Palmer stated earlier, after today's call we will be preparing an audio tape, a written transcript, and posting the slides so that others in your facility who were not able to listen today can do that at a later time and still have the information.

Moving on to slide 6, we'll mention that we plan to have additional outreach and educational efforts and we'll be working with the Cooperating Parties on some of these. One thing that we're trying to develop for you is a list of common myths. Some of the things that we're hearing out at meetings and early educational things that aren't quite right. And we hope to get some documents to correct these common myths so that we make sure that everybody understands exactly what's involved in moving to ICD-10. In addition to CMS doing this outreach, others are doing their own outreach efforts and sometimes in greater detail. AHA and AHIMA have started their outreach effort and they're planning some detailed, train the trainer type activities. AHIMA's obviously going to be doing some training - detailed coding initiatives to train coders. And we will, at CMS, be

deferring to professional organizations such as AHIMA for the detailed coding and learning to use ICD-10.

Moving on to slide 7, another issue discussed in the ICD-10 Final Rule was how we update and maintain both ICD-9-CM as well as ICD-10. We have a public meeting - that - committee that meets twice a year called the ICD-9 Coordination and Maintenance Committee. This committee usually meets in March and September of each year and discusses proposed updates to ICD-9-CM as well as ICD-10-CM and ICD-10-PCS. We use this avenue of the public meeting to get industry input before we make changes to these coding systems. Obviously, after ICD-10 is implemented in 2013, we would rename the committee to the ICD-10 Coordination and Maintenance Committee. Some people have noticed that the number of codes we have in today's slides and reading the proposed versus the final rule, mentioned that the number of codes seems to have changed over time and that's true. We update ICD-9 codes each year so the code numbers change. And we've also been maintaining and updating ICD-10-CM Diagnosis and ICD-10-PCS Procedure Codes. So in any given year the code numbers change as we update these coding systems. To read detailed information about what's discussed at the Coordination and Maintenance Committee, I've provided a website link on the bottom of slide 7. And in mid-August you'll be able to see an agenda posted for the September Coordination and Maintenance Committee.

Moving on to slide 8, I discuss this next meeting - the Coordination and Maintenance Committee. There's a very important item on this agenda. And if you haven't heard about it you really should, if you can, attend the meeting. If not, read the Summary Report afterwards and submit your comments on a very important issue we're going to discuss.

In the proposed rule - the final rule comments people wrote in and said they felt like it was important that CMS and CDC consider freezing updates to the ICD-9-CM coding system and the ICD-10 coding system prior to the October 1, 2013 implementation. They stated that - this, by freezing the code - it would be a little easier to develop educational materials for the implementation without worrying about updating them each year. They felt that vendors could develop products if they had a stable coding system for more than one year. And they stated a number of reasons why they felt like it would be good to consider having a freeze in advance of the implementation. In the ICD-10 Final Rule we said that we would take this issue to the ICD-9 Coordination and Maintenance Committee and seek input from various providers, and vendors, and others on what they thought about this suggestion. We'll ask them: Should there be a freeze? And, if so, should it be of both ICD-9 and ICD-10? One or the other? When should the freeze begin? For instance, should the last time ICD-9-CM codes and ICD-10-CM and PCS codes be updated be October 1, 2012? Or should a freeze be established as early as 2011? Do we need one or two years prior to the update and not update the codes on the date of implementation? These were the kind of things that we need from the industry. We'll be actively soliciting input from you to think about if there should be a freeze. And if so, when should the freeze be? Those of you who can come to the meeting and discuss this, we'd be happy to have you there. You can register for the meeting starting about August 14. I've given you the website to register. We will have a small number of phone lines available for people to participate and listen by phone. And many of you who can't come or participate, we would urge you to write to us after the meeting and give your own input. And we'll consider those just as much. But do consider in your

organization how important you think the issue of the freeze is, and if there should be one, and when it should be.

Moving on to slide 9, I'll discuss some of the resources that we have available right now on CMS and CDC's websites. We have the complete coding systems for ICD-10-CM and PCS, including the guidelines. We have the General Equivalency - Equivalence - Mappings, the GEMs, that we'll be discussing today. We have those that go both ways between ICD-9 and ICD-10. We have a User's Guide that explains how to use these GEMs in great detail. We also have a custom map that I'll be discussing later today called the Reimbursement Mappings. And lastly, we have something else that I've discussed - I'll be discussing today - and that's the conversion of our inpatient Medicare coding system, the Medicare Severity Diagnosis Related Group, MS-DRG - the conversion of that system to ICD-10.

Slide 10 simply gives you a quick way to click and find the ICD-10-CM Diagnosis Coding System. It looks very similar to a coding book. When you click - open that - you can see a tabular part and an index part along with the GEMs, and a User Guide, and full title code titles also. The ICD-10-PCS procedure files - you'll note that that's interactive. You can click on the table in the index and get to the table. We also have the GEMs for this coding system and full titles of the ICD-10-PCS codes.

Moving on to slide 11, I'll tell you - who we think of - who the ICD-9-CM users are and what they'll be replaced with. Right now, all providers use ICD-9-CM diagnoses to report Diagnosis Codes. The ICD-9-CM Diagnosis Codes will be replaced by ICD-10-CM, which are the Diagnosis Codes. The ICD-9-CM Procedure Codes are only used by

inpatient hospitals. And those inpatient hospitals will stop using ICD-9-CM for discharges right before October 1, 2013, and they will begin using ICD-10-PCS codes. Once more, those using CPT and HCPCS will not be impacted by this move to ICD-10 - you'll continue using those in their current setting.

Slide 12 talks about why we made the decision to move away from ICD-9. And I think most of you on phone know the coding system's 30 years old, much technology has changed, many of the categories are full - and by that I mean that when some of you have asked us to update the coding system with ICD-9-CM, we've had increasing difficulty trying to find space to put these new codes. Also, ICD-9-CM is really not descriptive enough and it's particularly a problem on the Procedure Coding System. So many of the codes from this 30-year-old system don't tell the approach used and some of the newer devices and techniques. We've had a very difficult time trying to get those into ICD-9-CM.

Slide 13 talks about the worldwide experience with ICD-10. While this seems like a big deal to us and we're moving very rapidly, the rest of the world for the most part has already moved to ICD-10 - many of them you'll notice for over a decade - and they didn't have that difficult of a time doing it. On slide 13, we showed some countries that not only are reporting - coding and reporting - ICD-10, but they are using them for more advanced things such as reimbursement and case mix. And we give you an example of some of those countries on slide 13.

On slide 14, we'll discuss some of the differences between the ICD-9/ICD-10, beginning with diagnoses. As you know, ICD-9-CM has from 3 to 5 digits. For most of the book, Chapters 1 through 17 - the codes

are - the characters - are all numeric; they're all number codes. We have two supplemental chapters where the first digit is an alpha character - an E for external causes of injuries and a V code, which is some codes for factors influencing health status. But all the rest of the codes in ICD-9-CM diagnosis are numeric. And at the bottom of slide 14, I just show you an example of a 3, 4, and a 5 digit ICD-9-CM code. And one of these is an alpha character and includes a V code.

Slide 15 shows how different ICD-10-CM is. ICD-10 can have digits as few as 3 and as many as 7, so it is 2 digits longer than the longest ICD-9 code. The first digit is an alpha character, A through Z, and it’s not case sensitive. So - you - it can either be capital or small. Digit 2 is always numeric. Digit 3 is either alpha or numeric. And the alpha characters, once again, not case sensitive. Digits 4 through 7 are also alpha or numeric. And at the bottom of the slide - 15 - you'll see some examples of codes ranging from 3 to 5, up to 7 digits long. You'll notice - that - the introduction of more alpha characters and you'll notice - the - up to 4 digits beyond the decimal on the right.

We'll now discuss slide 16, which is about the Procedure Coding System used by inpatient hospitals patients. ICD-9-CM has 3 to 4 digits. All 4 digits are numeric. And I show you an example of one of the few 3 digit codes - 43.5. And another 4 digit code - 44.42. When you think about 4 digits and all being numeric, you can understand how we've had difficulty expanding this coding system to capture the wide range of procedures we're performing today - it's just not possible with this limited number of digits.

Slide 17 shows how we've extended our ability to catch a lot more detail in a single code. ICD-10-PCS has 7 digits. And each of those

digits can be either an alpha - and again not case sensitive - or they can be numeric. We used the numbers 0 through 9; however, we decided not to use the letters O and I. And we did this to avoid confusion with the numbers 0 and 1. So in an example you see below, those are beginning with an 0 and then we're not using the letter O and I, once again. And you see these 7 digit code numbers that intermix between numeric and alpha characters. And you'll see how much information can be captured in one code, such as what you're repairing and the approach you're using.

Moving on to slide 18, we'll discuss the number of codes that are available in this year's 2009 version of both ICD-9 and ICD-10. The ICD-9-CM Diagnosis Codes - there are 14,025 codes. Look at how that expands into ICD-10-CM where we move up to 68,069 codes. And under the ICD-9 procedures, we go from just a little under 4,000 Procedure Codes all the way up to 72,589 codes. So there's a whole lot more detail and more codes. Looking at this increase and having explained to you how the codes are made up different, you can see how it would be helpful to have a tool to understand how to convert ICD-9 codes to ICD-10.

And slide 19 discusses just that tool, the General Equivalence Mappings. Since the codes ICD-9 and ICD-10 are so different, we realize that people that are converting large data sets would need some assistance. One could simply open up a book, and look up every code you wanted, and to figure out the code in ICD-10. We've basically done a lot of that for you - by looking up ICD-9 codes, considering the code titles, the index, other rules about the book - and we've tried to find all the general equivalence meanings there might be to similar codes in ICD-10. We've also done that in the other direction -

bi-directional from ICD-10 codes - to get them back to the general equivalent meaning of the ICD-9 codes. Having these lists of similar codes, we hope that the list would be useful in finding and replacing lists of codes so that you could replace the list of ICD-9 codes with the general equivalent codes in ICD-10. Now, I'll mention that these GEMs - these mappings - are a useful tool, and they'll help you convert large data sets. However, they won't be a substitute for learning how to code with ICD-10. Starting about six months ahead of implementation or a little shorter, you should have a plan to begin learning seriously how to use ICD-10. And training to use either the code books or the encoders that will be widely available on the market and learning how to use those. If you're using the GEMs to convert data, you'll also find that you'll want to pick up that coding book or encoder to check which of the applicable similar codes in ICD-10 you'd want to select for your own use. So when using the GEMs, you'll still be going back to that source tool of the code system. Today, as I mentioned earlier, we're going to discuss an overview of the GEMs - the mappings - what are in the GEMs, where can you find them. I'll tell you how to use the User Guide for more information. And after the call today, I hope that each of you will be comfortable enough that you'll go to our ICD-10 website and actually find the GEM files, open them up, look at them; open up the User Guide and the fact sheets. You can sort of look at this as job security. You'll be the ones - the people in the industry - who will understand how to convert codes with ICD-9 to 10 or back. You'll know where the tools are. And if it's appropriate for your institution, you can tell others how to do this. And those of you who work in a facility now who don't need them, perhaps within four years if you're in another institution, you'll maybe have a need to use these. And I hope we can explain and make all this information available so if you do have a future need, you'll know how to use this information.

Moving on to slide 20, I talked about the GEMs being bi-directional - and by that I have a pictorial explanation. There's a mappings that goes from ICD-9-CM diagnosis - that's the source code - to convert it to the target code. In other words, convert it to the ICD-10 codes - the ICD-10-CM. We call that forward mapping - mappings that - call - comes from the old system, 9, to the new system. We also - and you will find out that you'll also need to use the backward mapping code. Sometimes you'll pick up the ICD-10-CM book, you'll look at the code, you've got an application for it, you'll wonder what the predecessor codes were in ICD-9-CM. And you'll look that up in the ICD-10-CM backward mapping file that takes you back to the previous codes in the ICD-9-CM. We have these forward and backward mappings for both ICD-9-CM for ICD-9-CM diagnosis as well as forward and backward mappings from - ICD-10 - 9-CM procedures to ICD-10-PCS procedures. And, once again, you'll find that you use both - the forward and the backward mappings - in converting data. You can think of these mappings as a bi-directional translation dictionary. If you picked up a Spanish or a English dictionary today, you would find in one section that it's the Spanish words and their appropriate general equivalent English code for it. Or you could switch to the back of that dictionary and find the English words and then find the closest Spanish equivalent for it. And that's the way these mappings work. They are a perfect mirror image of each other. You'll see examples of that later in the slides.

Moving on to slide 21, we'll discuss the use of the GEMs to convert a payment system. When we developed the GEMs and we got comments in after the proposed rule, we had some providers and payers who called and said, "Well, we see you have the General Equivalence Mappings, the GEMs. However, we're not sure if they

work or how well they work. And we would like some reassurance that they are good tools." And, frankly, that was a good point. We developed the tools. We needed to see how well they worked. CMS decided we would be the first one to test it. We picked one of our most complicated payment systems and that's our inpatient Medicare Severity DRG system - Diagnosis Related Groups. And we decided that if we could use those GEMs to convert the MS-DRGs from ICD-9 codes to ICD-10, then we would be pretty sure that they would work very well on other kinds of data conversion tasks which were not nearly as complicated. We selected the digestive part of the MS-DRG payment system to be our first exercise. That's called the Major Diagnostic Category 6, and it's a reimbursement system for inpatient cases that have digestive types of diagnoses and procedures. We did that task, we used the GEMs, we converted that part of the DRG system from ICD-9-CM to ICD-10, and we presented our results at the September 24, 2008 ICD-9 Coordination and Maintenance Committee. For those of you who did not attend or have not heard about this exercise, I would urge you to read the Summary Report along with the slides we've posted for that particular meeting. And see what we did and what we learned. It went so well, frankly, that instead of picking one or two more parts of the DRG system to convert, we decided we would set ourselves up with the task of completing a total conversion of the MS-DRGs to an ICD-10-based by October 1, 2009. We are pretty far along on that task now - we've already converted the medical DRGs for the entire system, and now we're working on the surgical DRGs to convert those to ICD-10.

Moving on to slide 22, I'll discuss what we did. In the MS-DRG conversion our goal was, frankly, if a patient is admitted to the hospital and coded now in an ICD-9 code, they're assigned to a payment group

- an MS-DRG. Our goal was that if that same patient was coded not with ICD-9 but with ICD-10, then they should arrive in that same payment group - the same DRG. So we wanted each DRG converted from ICD-9 codes to the very equivalent ICD-10 codes so that we would be paying the same, they would be clinically equivalent. And those of you who are familiar with our definitions manual that lists codes under any DRGs, we wanted the definitions manual to look similar so that users would understand what we were doing. On the slide 22 to the right, we just show some Diagnosis Codes that are listed in the diagnosis part of the DRGs. The asterisk just shows that it was abbreviated down to a category - why - it was just to save room on this page.

Turning to side 23, I'll show you how we approached updating a medical Diagnosis Related Group - medical payment group. And this one is for a set of three DRGs that have to do with inflammatory bowel disease. On the left side you'll see some principal diagnoses - four of them - four codes for enteritis that would lead the patient to be assigned to one of these payment groups for inflammatory bowel disease. What we did is - we looked at the GEMs and we found all the equivalent codes in ICD-10 for these four codes. In other words, we would find all the relevant codes, their applicable codes, and we placed them under that DRG. There were 28 ICD-10-CM codes that were equivalent to the four ICD-9-CM codes. And so you see a picture on the left of the ICD-9-CM version of our DRG, and on the right you see a list with some of the ICD-10-CM Diagnosis Codes from the search and replace exercises using our GEMs.

Slide 24 shows a surgical DRG. We have medical DRGs and surgical DRGs in the inpatient payment system. Under this particular set of

DRGs for adhesiolysis adhesions, we had two Procedure Codes that are shown on the left - 5451 and 5459. We saw the equivalent codes in ICD-10-PCS and there were 112 Procedure Codes equivalent to those two ICD-9-CM Procedure Codes, and so we replaced them in the DRG. And the reason there's more detail, if you notice, is that we actually tell where we had adhesions, what part of the body, and what approach was used. So there's a lot of valuable information here. And the patients in the payment groups will be clinically consistent because they're going to be assigned to the same DRGs based on whether the ICD-9 Procedure Codes were used or the ICD-10-PCS - what precise codes they used.

Slide 25 shows the size of the task we were faced with. On to the MS-DRGs - the inpatient payment system - there are a lot of lists of codes. And we have to convert each of those lists to work out the logic. The chart shows that there are about 200 unique lists of codes that are just Diagnosis Codes. There are also 300 lists of unique codes for Procedure Codes. So we had a total of about 500 lists of codes we had to convert from ICD-9 to ICD-10. Using the GEMs - the mappings systems - we were able to auto replace - find and replace - 92 percent of the Diagnosis Codes, which surprised us pleasantly when we saw that high number. We were able to find and replace - using the GEMs - 91 percent of the Procedure Codes. And the reason for that you'll see in some of the additional slides. We have so many imprecise codes that - so many vague Procedure Codes - that many times we would have to analyze these and look at them clinically to decide how to handle them. But the bottom line was - in the digestive part of the DRG system - using the GEMs mappings we were able to convert to ICD-10 codes in 95 percent of the time using the GEMs. So 1 percent of the Diagnosis Codes required this clinical review to figure out how to

reassign the codes and 9 percent of the Procedure Codes. Now, based on the work that we've done, we felt like after the digestive chapters that just by setting up some simple rules and approaching it a little bit different, we could reduce that number so that even greater than 95 would be able to automatically replace in the future editions. And I'll be explaining some of these rules in the upcoming slides, but it did prove to be the case.

Slide 26 shows the problems we're faced with with converting the DRG system because of these overly broad ICD-9 Procedure Codes. Looking at the list on the right, you can see, such as - one of - the first one on the list - 92.27 for radioactive element implant. There's another one - 81.96 for other joint repair - where we don't even know which joint's involved with that code. 39.31 - suture of an artery - and, once again, we are not even sure what part of the body this artery is that we're suturing. On the left side of slide 26, we mentioned that there are approximately 200 of these overly broad ICD-9 Procedure Codes. And these make it very difficult to update our DRG system. The question is - if you have this overly broad code, you use the GEMs, and you find all the precise ICD-10-PCS codes that are equivalent to them - do you assign all of those codes into the same spot where this one came out of or a subset of them? That's the question. Looking at the first code on the list at the right - the code 92.27 for the radioactive element implant - there are 261 ICD-10-PCS codes associated with that one for the element implant.

And I'll show you why if you look at slide 27. On the radioactive element implant - these implants in PCS - there's information about how you got the implant in, the approach, and where we put the implant. Well, given this information, it doesn't really make sense to put

all of those implants into the digestive payment group. Under our Digestive DRG System, we have a set of DRGs - DRGs 356, 357, and 358 of the Digestive System O.R. Procedures. And that code 92.27 - implantation on insertion of radioactive element - is assigned there. The question is - do you want to take all of the 261 codes for radioactive implant and put them into that Digestive System Surgical DRG? And we decided no - it was only appropriate to put ten of them. And those ten are the ones that have something to do with the digestive tract. So on slide 27 on the left, obviously, a PCS code that would show implantation of radioactive element into the esophagus makes sense to include in that DRG as well as the one where you insert it into the rectum. On the right side of slide 27, it really doesn't make a lot of sense to put the radioactive element implant into an eye, lung, or breast into a Digestive System O.R. Procedure Code. So we are going to take these vague codes, work up logic about which body system was involved, and use that to automatically update some of our future DRGs that we're doing throughout the body.

Slide 28 shows another issue that required some medical review - some closer examination - and that involved some code conflicts. There are times, even though that ICD-10-CM is much more precise than ICD-9 and there'll be many more ICD-10 codes than ICD-9 - there are some times when there's one ICD-9-CM Diagnosis Code that was previously assigned in more than one ICD-9 code. And those two codes could be in different payment groups - different DRGs. And we show you an example on slide 28. On the left, we have an ICD-10-CM Diagnosis Code for other specified heart diseases. On the right, we show the two ICD-9-CM codes that captured this before. The code at the top, 398.99, other rheumatic heart disease - was assigned to one set of DRGs - DRGs 314 through 316. But the other code, that was a

predecessor code, went into an entirely different set of DRGs - 306 to 307. Now, the question is - given that the GEM mappings tell us that this one code came from two different ones and we know that they paid them separately - which payment group do we put the new ICD-10-CM Diagnosis Code in? Well, in this area where we had conflicts, what CMS decided to do is - we looked at data for cases that reported these and we looked at how frequently they occurred. And we found within our Medicare data that the code 398.99 is hardly ever used - very rare. The code that's used most frequently is 397.1 - rheumatic diseases of pulmonary valves. And for that reason, we selected the DRG's assignment for that second code - DRGs 306 and 307 - and we said that will drive the conversion of the ICD-10-CM code I09.89. So, in other words, that ICD-10-CM code would go to DRGs 306, 307. Because of the two predecessor codes, we went with the one with the greatest frequency. Now, if others were doing other conversions - and for your own payment system or analysis for whatever purpose and - you had different payment populations, you may use the GEMs and make different decisions based on your own population. We show you simply how we use the GEMs to convert our Medicare payment system for inpatient using Medicare data.

Turning to slide 29, we'll discuss some additional uses of the GEMs to convert payment systems. We plan to discuss progress at future ICD-9 Coordination and Maintenance Committees of the use of the GEMs and conversions of the data. The next meeting, as I told you previously, is September 16 and 17, 2009. It's here in CMS' auditorium in Baltimore. In addition to discussing whether or not we should freeze the coding system, we're also going to be reporting back on the progress we've made in converting the DRGs - the inpatient payment system - from ICD-9-based to ICD-10. We will be sharing additional

lessons learned. We will be responding to individual questions that are raised. And for those of you who are doing similar projects with other settings, other needs, who want to come and ask us questions about using the GEMs based on our own experience in converting the DRGs, we would be happy to try to answer those questions at the meeting. We have already posted the work we've done to date of converting the digestive part of the DRGs to our website. We will complete the ICD-10 Grouper - that's the ICD-10 version of the inpatient payment system - by October 2009. We will get input from people at the September meeting. We will discuss how this should be displayed so that people can analyze it in the most easy fashion. And we will post the complete updated ICD-10 version of the Grouper - the inpatient payment system - by the end of 2009. Now, I should mention that - there will be - the final Grouper logic will be subject to formal rulemaking just as we do each year when we update the Inpatient Prospective Payment System. The purpose of this exercise is to show people how to use the GEMs - learn about using the GEMs. And if we need to maybe make modifications to them. And suggest to other people how they could use them for their own purposes. It also, I think, when we get to formal rulemaking on the Grouper, will help people understand what thought went into conversion, how to approach it. So I think it will help everybody who's commenting on the final Grouper to have gone through this exercise and have these files freely available. I give you, once again, the place where we're going to be posting the Grouper logic work that we've done so far and where we'll be posting the complete Grouper logic when we're finished it.

Moving on to slide 30 and we asked the question - and you probably already know the answer - why do we need the GEMs? Well, one reason is ICD-10 is so much more specific. There are more codes.

There are more details. We've gone over - the - how much increase in code numbers once before and I show them to you again.

Slide 31 gives an example of how the GEMs work and why we need them. ICD-10 is much more specific than ICD-9. And on this slide, 31, I show one ICD-9-CM Diagnosis Code and you'll see the multiple ICD-10 codes that would be equivalent to that. Using the GEMs, you will be assisted in finding those additional codes that were equivalent to 82002. And this would be using a forward map because we're going forward from ICD-9-CM to ICD-10-CM.

Slide 32 shows that sometimes the reverse happens - sometimes you have one ICD-10-CM Diagnosis Code and it’s represented by multiple ICD-9-CM codes. So for this diabetes code in ICD-10 at the top of the page, it would map back to the equivalent of three equivalent codes under ICD-9-CM. Clearly, this is an example of using the backward map of ICD-10-CM because you're mapping backwards from ICD-10-CM code E11341 back to the ICD-9-CM equivalent code.

Slide 33 shows something that maybe you hadn't thought about and that's that sometimes ICD-10 has new concepts that never were in ICD-9-CM. And you can find those easily in the GEMs. Here I have an example of some T500X6A codes and others that are trying to capture underdosing. If you tried to look up underdosing of certain medications in ICD-9-CM, you wouldn't find an equivalent code. So using this backward map from ICD-10-CM back to ICD-9-CM diagnosis, you would have an indication that there's no predecessor code available. This a new, unique thing in ICD-10-CM.

Also, slide 34 shows you other complexities to try to map between the codes that these GEMs assist you with. Sometimes ICD-10-PCS codes - one of them will capture multiple ICD-9-CM codes. And one of the examples, I guess, that probably drives inpatient hospital coders the most crazy is trying to code angioplasty codes where you have to have separate codes for the angioplasty to tell the number of vessels involved, if you used a stent, if it's drug eluting or not, and if there was a vessel bifurcation. It takes separate codes to capture all that information. With ICD-10-PCS, one code captures more. Now, this is an example of a backward map - mapping backward from ICD-10-PCS back to the ICD-9-CM Procedure Codes.

Slide 35 shows the opposite of the previous one. In this case, we have suture of the skin code in ICD-9-CM codes that's captured by multiple ICD-10 codes. And if you notice, all the sites and the approaches get described more clearly - how the suture of the skin is done and the type of repair. This is an example of a forward map from ICD-9-CM Procedure Codes to ICD-10-CM Procedure Coding System.

So - map - for slide 36, I tell you where you can find the GEMs - the forward and backing maps for both Diagnosis Coding System ICD-10-CM and the Procedure Coding System ICD-10-PCS. Depending on your use, you probably will use both. But depending on which one you want to start with and what you want to do, you analyze it one way - forward or backwards. Also, there is a very useful document that I would urge all of you to look at and that's the User Guide. The User Guide tells how to use the GEMs and it gives a lot of helpful hints that we're not going to get in today. But if you forgot some of the things that we went over today or you feel like you need to dig in and do it a little

more closely, then I would urge you to read the User Guide to find out how you can make your job of converting data easier.

We'll now turn to slide 37, and we'll start learning about the GEMs files. On slide 37, on the right side, it's just a little picture. If you open the GEM files today and look at them, that's what a section of one would look like. The first column in this particular example - this is from the ICD-10-CM mapping - it's a backward mapping file beginning with ICD-10-CM. On the left is the ICD-10-CM code and we call that the source code - that's the one you're working from. You know what this code is and you want to know what ICD-9-CM code or codes are equivalent to that code. So the middle column shows you the target code - we're trying to convert to this - and it shows you the option or options. The column on the right is a series of flags that will assist you even further in converting data. Once again, this is a backward map starting with ICD-10-CM and going back to ICD-9-CM.

Let's look at this in a little more detail and understand what all this means. And if you look at 38, I've taken a picture of just a few of the codes at the top of this GEM file. And you'll notice the first one - the source code - the ICD-10-CM source code is T1500Ax. And you'll notice that's listed twice - it's there twice. The target code to its right - you see two separate codes - you see 9300 and E914. And, as I'm sure you probably know, we're saying that that code - that T1500xA - has equivalence of two codes in ICD-9 and those codes are 9300 and E914. Going down that same list, you'll see that T1500xD is also listed twice and it also provides two codes in the middle column associated with it. So T15xD is two equivalencies under the targets codes - it takes both 9300 and E914 to be equivalent to T1500xD. Looking at the last entry into our little column of GEMs codes, we see T15xS - it's only

listed once. It has one code beside it - one ICD-9-CM target code - 9085. And what this is trying to say to you, in general, is the equivalent code for T1500xS is code 9085. Below it you'll see that I have inserted full titles for each of the ICD-10-CM codes and explained what those two matching codes are under the xA code - the full titles. You can do this yourself since we provided on our website the full coded titles for all of these GEMs. So if it's easier for you to simply make your comparison and insert the code titles to read them, then you can do that also. The User Guide gives you information on how you can accomplish this.

Let's move on to slide 39 where we'll get down into - the - a little bit more of this issue. We'll discuss the flags. The flags, as I've told you before, are the far right corner - the far right column - the third of the three columns. This particular case, I've used an illustration of the ICD-10-PCS code as the source code. The target code we're trying to convert these to are the ICD-9-CM Procedure Codes, so then we have the flags that modify them. Well, if we just look at this first - the first 2 columns - you can probably figure out some of this yourself. You see that same ICD-10-PCS code listed six times and in the right column you see six separate ICD-9-CM Procedure Codes. And what that's trying to say is that it, you know, the equivalent mapping takes you to six ICD-9-CM Procedure Codes. This is example of backward mapping taking you back from ICD-10-PCS back to ICD-9-CM. Well, the flags will tell you some of the same information and we'll discuss them. The flags - if it's a 1 it means that we've turned the flag on. 0 means it's off. There's three different, main kinds of flags. The first flag - the first one in that set of five numbers - is an Approximate Flag. The second flag is the No Map Flag. Flag 3 is a Combination Flag - meaning it takes more

than one code. And then Flags 4 and 5 give more details that have to do with that Combination Flag.

Let's move on to slide 40 and we'll discuss that first flag - the first number in that column of the flags for the Approximate Flag. If there's a 1 - and you see that the bottom of the page of slide 40 I've bolded 1 and underlined it - it's the first flag. A 1 means that the translation of these codes is an Approximate match - it's not identical. Now, obviously, you would expect to find many Approximate matches - if every ICD-9-CM code had an identical match with ICD-10 codes, then there really wouldn't be much purpose in moving forward because all the codes in the concept are identical. Since there's more details and more specificity in these codes, then you'll expect to find more Approximate - not exact matches. And that's true. So the majority of entries you'll see in that flag - the first Approximate Flag - will have a 1 and that's because they're Approximate matches, not identical. When you see a 0 in that first column of flags, that means the translation is an Identical match - it's a perfect match from ICD-9 to ICD-10. It's very rare in the procedure GEMs to have an Identical match. And we see a little more common cases of that in the diagnosis GEMs. At the bottom of slide 40, I show you an example of an Approximate match - they're not identical. And you'll see that code T1500xA takes two codes for equivalent meaning and they're Approximate. And some of the reasons that they're Approximate is some of these codes describe the initial encounter, which is in those ICD-9 codes. So if it's not a perfect match even with those two, it's going to be an Approximate match.

Slide 41 also discusses the Approximate Flag - that first flag. And in this one I show you an example where the flag is a 0 and that means the translation is an Identical match. In other words, the ICD-9 code

414.11 - for aneurism of coronary vessels - if you were to look that up in your forward mapping of the GEMs, you would find that the target code 414.11 - the middle code I2542 for the ICD-10-CM code. And that 0 says that they're Identical matches - there's one code and they actually happen to be identical in this rare case - so the 0 is an Identical match.

Moving on to slide 42, we'll discuss the No Map Flag. This is the second column of the flags. You'll notice in the middle of slide 42 - I have bolded the 1, underlined the second flag in that series of five. Where there's a 1 in the No Map Flag, that means that there are no plausible translations between the source code and the target code. In other words - if you're - in the example here, below, where we have an ICD-10-CM Diagnosis Code - we don't have an exact match in ICD-9-CM. If there's a 0 in the second flag, that means there's at least one plausible translation from the coding system. So I've showed for you in the middle an example - T15x6A, 6D, and 6S - where there is a NODX entry, in addition to saying the 1 is the second flag - the 1 meaning there's No map. And I've reaffirmed it with a NODX in the middle - spelling those out with full code titles below. You see that this has to do with the issue we discussed earlier, which is underdosing - is a new concept in ICD-10 which we did not have in ICD-9-CM. So, obviously, you would not be able to map back. This also illustrates the critical importance of using the forward and backward mappings. Using the ICD-9 to ICD-10 mapping, you wouldn't be aware of these. But if you go to a payment system - like we are - or quality measures, make sure that all of the codes in ICD-10 are analyzed and classified, you would see these. NODX is the 1 Flag in the No Map. And you would know that you've got a new concept that you need to handle in whatever

data system or whatever you're working with. You expect it to be easy to find these terms and spot them.

Moving on to slide 43, we have the Combination Flag. And - that's - this is Flag 3 and also further clarified by Flags 4 and 5. I have a picture once again in that left block where you see part of the GEMs and you see the third flag over. If the third flag over is a 1 - it means the codes mapped to more than one code. And let's see if that was true. Looking at T1500xA - that's listed twice - and we have two codes beside it. And, yes, the third mapping code says it takes more than one code to be equivalent to that one code. So if you will look at these by line-by-line basis and you saw that 1 in the third column, then you need to scan further to see all the combinations that go with the code and the source code file. Looking at the next one in that list - T15xD - it's listed twice. There are two codes beside it. And let's look at the flag - the third flag over is in fact a 1 and it means that the code mapped to more than one code. I've spelled out for you the complete code titles - what they mean - on the right. And if you're doing your analysis I think, once again, using the User Guide, you may find it helpful to input the full code titles in for your own analysis. Now, Flags 4 and 5 give more information that clarify these combination entries. But we're not going to go through all that today. I would urge all of you who are going to be doing these and getting down to this level of detail to read the User Guides and further understand more detail about using these combination equivalencies in the GEMs files. But one thing you can see based on all that we've learned so far, is how much time this could save you by using the GEM files and grouping together the codes that are generally equivalent for an existing code. Then based on whatever you're using this translation for and the information, then you can make

decisions about how to use the translations and which codes are appropriate for your use.

Now, we're going to move on to another topic that I want to go over briefly and that has to do with a custom map that we've created. We call it the Reimbursement Mappings. When we created the GEMs mappings and published it on the web page, people were very appreciative. And they were very interested in using them, but some payers found this level of detail in the GEMs daunting. And they asked us specifically to develop a more streamlined mapping system for their own reimbursement purposes. This could be used if ICD-10 codes were submitted on a certain day and the payer wanted to decide how to pay them. This Reimbursement Mapping - the goal would be to look at each ICD-10 code that came in the door, analyze it, and decide what ICD-9 code would have been used in prior times. And they could pay them the same. So this is streamlined thing used for payers who choose to use it for an interim time period where they're trying to convert their legacy systems to pay based on ICD-10. So it still would accept ICD-10 codes but their own internal logic might convert it to an ICD-9 for payment purposes. It gives the one-to-one best map and it occasionally gives a cluster of codes when required. Now, the Reimbursement Mappings simply provide a simpler way of conversion of codes for reimbursement purposes for use in legacy systems. Now, CMS is not going to be using the Reimbursement Mappings. We are actually - if you heard earlier - we're using the GEMs to convert our payment system logic itself. We're converting the system so when they come in, we'll pay on payment system based on ICD-10 logic. But we did develop these Reimbursement Mappings at the request of other payers. And if people find them useful, then they are free to use them.

Slide 45 talks about how we developed these Reimbursement Mappings. We started with the ICD-10 to ICD-9 GEMs - the backward mappings for both ICD-10-CM and PCS. When an ICD-9 code is translated to one code - only one code - then we didn't have to do anything else. No review was necessary because we knew the predecessor code. Ninety-five percent of the ICD-10 codes are translated back to a single ICD-9 code. So for payment purposes, you can look at these codes and see exactly how they used to be handled. Now, many of these ICD-10 codes that translate back to the same code - they - actually many of the codes will go to the same code. So there's a lot of repetition with the details.

Slide 46 shows that where one ICD-9 code - I'm sorry - where one ICD-10 code is translated to more than one ICD-9 code, then we use historical ICD-9 code frequency data to determine the most commonly used ICD-9 code. We saw that earlier when we talked about that rheumatic valve disease - where we had two codes with the mappings were back to two, and we picked the one that had the higher frequency. To make these decisions for the Reimbursement Mapping, we used our own MedPAR database, and we used California database for newborn and obstetrical codes. In the vast majority of cases, there was a clear dominant case for us in case of frequency. In some rare cases, we had to use clinical review to decide - to make a final choice. Now, for those of you who would choose to use the Reimbursement Mappings - and perhaps maybe don't want to use Reimbursement Mapping based on Medicare data - you have your own data, then certainly you could do the same task. You could use the GEMs and use your own data to maybe arrive at some different codes occasionally.

Slide 47, I'll just show you how to read the mappings if you decide to open and use them. There's three columns: on the left side we have the ICD-10 codes, in the middle column there's the digit that tells how many ICD-9 codes are required for the complete translation, and then the right column shows the ICD-9 code or codes. So for the example for the ICD-10 code of S72032G, we see on the mappings there'll be a letter - a number - 1 that means only one code's required to map it back to ICD-9 and that code is 82002. Now, I found for you in the ICD-10-PCS Reimbursement Mapping example where that's not the case - where it takes more than one. And we have this other code - 02733D6 - has a digit in the middle that says 5, meaning that it takes five ICD-9 codes to be equivalent to it. And then I show you the ICD-9 code cluster there that takes the equivalent. Now, remember that in using the Reimbursement Mappings, these are only backward mappings because they are only taking you back from ICD-10 back to the ICD-9 code for reimbursement purposes.

Slide 48 discusses the use of mappings. We designed the GEMs and the Reimbursement Mappings for use by all providers, payers, and data users. You are free to use them. You do not have to go out and create your own. We paid for these - the development of them. We believe that they are good tools that will assist you in converting data. We make them publicly available on the CMS and CDC websites for you to download and use. We plan to continue updating and maintaining the mappings so each year that we update ICD-9 or 10, we have to update the mappings. And we will once a year continue to update these maps and post them. Vendors who choose to take these mappings and use them in their products - you can feel free to do that. These are public documents for your use.

Slide 49 discusses some of the use of the mappings. The first one - you can use them to convert payment systems and edits. And you see that we have done just that. We have used the GEMs to convert the inpatient payment system - the MS-DRG - to ICD-10 version. Other payers may use them to convert their payment system. You could use them to convert national or local coverage decisions. Also, quality measures that are being developed with long lists of codes - these GEMs would help begin that process of converting them, risk adjustment, or for analyzing trend data pre-and post-ICD-10. So they are greatly helpful with large amounts of data. I'll stress once again, they aren't something that you would just use and begin coding with them October 1, 2013 - it's quicker, easier, and more accurate coding routine cases to simply open your book or encoder and code. But in the meantime, as you're converting data and you want some assistance honing in on the right area, please use the GEMs. And then I would encourage you to open the ICD-10 book at the same time and review the decisions made. And depending on your application, select the codes that you feel appropriate. Before you begin deeply into the process, you'll want to review the GEMs and definitely read the User Guide. And what I would like you to do maybe next week sometime is when you open up the GEMs, just try converting a few codes. Take a couple of your favorite ICD-9 codes - so maybe if you're in a physician's office - that you see all the time. Use the GEMs so that you can get in the right part of the book and see all the code or codes that it would convert to. Then open our ICD-10-CM file on our web page or the code book itself - look at those codes and start analyzing what the codes look like. And start learning about the system so that you'll know how to use this - the conversion tools - and you'll become familiar with where the GEMs are. And you'll also see the coding system.

Slide 50 talks about the updates that we have routinely. I've gone over these before but I want to mention again - on our ICD-10 Web page we have the GEMs for 2009, diagnosis and procedures in the User Guide. We have the Reimbursement Mappings. We have the ICD-10 Digestive System MS-DRGs. And we have the complete version of the ICD-10-CM and PCS codes, the tabular and index, and the coding guidelines. All of that's ready for you to use for free.

In addition, on slide 51, we have general information on our ICD-10 Web page. We talked about the educational resources - some of them I know Ann Palmer sent out in advance of this meeting. But you can click on Educational Resources and find now and additional products later, such as helpful documents that answer the top questions about using the GEMs - a document explains how the GEMs work. There's documents that explain generally what ICD-10 is all about and how that will be used. And we plan to continue working on additional educational resources for you. Should you want to take these documents and mimic them for your own internal use and put your own logo on them, then you can feel free to do that. These are educational resources that you can use to train your own staff. We also have the Sponsored Calls from 2008 which - are - you heard mentioned. If you haven't heard the 2008 calls and want to listen to them - listen to the audio, review the slides. If some of your friends missed the 2009 session today and they want to listen to it - within - in the future, we'll have this audio tape up, the transcript, and slides so you can listen to this again. Once again, if you want to know why we made decisions about ICD-10 and what the comments were, you can read the final rule.

Slide 52 shows some information on CDC's Web page, particularly focused on ICD-10-CM - the diagnosis part.

Slide 53 shows some information that we discussed in our 2008 calls when we had AHA and AHIMA on. They have a number of documents of ICD-10 on their websites that you can access freely. You can use it to educate yourself and you can learn a great deal about ICD-10. And I would urge you to look at those slides and try to get better accustomed.

I want to thank everyone for their patience listening today. And I'm going to turn it back over to Ann Palmer in case there are any questions that I can try to answer for you. And I look forward to talking to you on future outreach calls.

Ann Palmer: Well, first, I would like to say that we understand there was some confusion about the start time for this call, and we do apologize for that confusion. Once again, we will be posting the transcripts in a few weeks on our website. And they can be found at www.cms.hhs.gov/icd10. On the left side of that page, you will select 2009 CMS Sponsored Calls. Christine, can we go ahead and start the question and answer session now, please?

Christine: At this time if you would like to ask a question, please press star followed by the number 1 on your telephone keypad. We will now open the lines for question and answer. To remove yourself from the queue, please press the pound key. Today's conference is being recorded and transcribed, so please say your name and organization prior to asking the question. Our first question comes from the line of Cathy Hawn. Your line is open.

Cathy Hawn: We'll pass.

Operator: Okay, our next question comes from the line of Patricia Cup. Your line is open.

Ann Palmer: Go ahead, please.

Patricia Cup: That was about the start time thing.

Ann Palmer: Okay.

Operator: Okay, our next question comes from the line of Karen Clark. Your line is open.

Karen Clark: Hi, this is Karen Clark with Christian Health. Side 47, you referred to the middle digit - and just - and how many ICD-9 codes would be used - to - for the equivalency. And on my slide I did not see that - so would you clarify that?

Pat Brooks: Yes. And, you know, I have to apologize. Some of the earlier versions of the slides were missing those two digits. And if so, then if you don't mind taking a moment now to write right after S72032G - put a number 1 for those of you who have an earlier version. And put a 5 - between - after the ICD-10-PCS code 02733D6. Since this time we have updated the - I - 2009 calls and that slide has been corrected. And thank you for pointing that out.

Karen Clark: Thank you.

Operator: Our next question comes from the line of Pam Brogan. Your line is open.

Richard Williams: Hi, thank you. This is Richard Williams, actually, instead of Pam. I had a quick question regarding the final conversion - this is a reimbursement question. Has any discussion been done to this point in time as to what FY year - like for instance - are you going to use 2009, 2010, 2011 data for determining the reimbursement? Because I know when they went live with the OPPS system many years ago, the data was several years old that they used. And I didn't know if there had been any discussion as to what final year data they're going to use for coming up with the MS-DRG payments under the new ICD-10 system.

Pat Brooks: That's a very good question. We anticipate the same time schedule that we have now. So - we on - if we update our DRGs, which we will propose in a proposed rule in advance of the FY 2014 year - so it would be for October 1, 2013. We use data that's about two years prior right now. And at that point in time, we'll still be the same. So to look at that - look at that DRG - if it's a heart failure DRG or if it’s a bypass DRG with ICD-10 codes, we'll look at two years’ prior data for those patients to make our analysis and to create our relative weight. So we anticipate the same timeframe that we do now. And all of this would be part of the routine IPPS update.

Richard Williams: Okay, well, as a follow-up to that then. If you're looking at, you know, typically two years prior which would kind of go on course with what MedPAR data, you know, is typically - it's 12 to 18 months old by the time you have all your final cost reports filed and the way that people's

years - file - fall on different dates. Do you feel that that will play or weight into the decision to freeze the ICD-9 or ICD-10 systems?

Pat Brooks: You know, that's what I would urge you, as people on this phone, to tell us. We very firmly believe that there's pros and cons to updating the coding system every year to keep up with technology. There's also benefits in freezing them so that we can analyze the data and update, you know, our system's going to get 10 codes. We will listen in September at the Coordination and Maintenance Committee on what the public feels are the most important criteria. And if they believe there should be a date - what date they believe. So it may vary by commenter, and we would urge people to think about that. And if you can't come to the Coordination and Maintenance Committee, you can look at that slide in the Summary Report - you can write to us, and tell us: “I have these thoughts. Here's things that you should consider.” We don't have any preconceived notions about the freeze - we just feel like it’s an important issue that we want the public's input on.

Richard Williams: Thank you.

Pat Brooks: You're welcome.

Operator: Our next question comes from the line of Thomas Moore. Your line is open.

Thomas Moore: Hi, my name is Tom from Hands On Physical Therapy. And on slide 41, you're using the example of an exact match, which is a 0 in the first column. And on slide 43, you have that T1500xS, which has an exact match of 9085 but it has a 1 in the first column.

Pat Brooks: You know - that is - I'm glad you raised that question because let me answer that for you. There's a difference between an exact match and only one approximate code. So sometimes there can be only one code. Oh, you know, did we or is that a typo? If there's only one code that converts between I-9 and I-10, then there's only one equivalent to it. That code can either be an exact match or not - that's two separate things.

Thomas Moore: Okay, thank you.

Pat Brooks: Yes, and I know this is difficult to understand that exact match but the good news - or the bad news - depending on how you feel about it, there are going to be very few exact matches where the content of it is totally the same. Most of them are going to be maybe one code that's an approximate or several codes that are an approximate.

Operator: Okay, our next question comes from the line of Debbie Nash. Your line is open.

Amy Choo: Yes, this is Amy Choo, First Coast Health. I have a question on slide 39 - and then you're talking about the Approximate Flag. Oh, actually, the Combo Flags - shouldn't the third indicator or the third part there on that last code, the 3609, the ICD-9 3609 - shouldn't that be a 101?

Pat Brooks: Yes, thank you so much. You know, we've a had a time getting all these things retyped. Very good. And those of you who are looking at these examples in here, it would be good for you - when you go to the GEMs - to look at the greater detail and catch the things I've missed.

Operator: And our next question comes from the line of Laura Frenzel. Your line is open.

Laura Frenzel: Yes, thank you. I'm wondering if there will be the option of having the mappings on a Palm type. We have nurses who have Palm systems that they take data out with them. Do you know if there will be any kind of conversion to a system that they can take out in the field with them? We are a Home Health Agency.

Pat Brooks: You know, all I can tell you is what we've developed and posted on our website is this application. It wouldn't surprise me if vendors created additional applications. Although, I should tell you, once again, these GEMs aren't something you would carry around and just routinely code from - you would want the code from the actual codebook itself - but an additional tool and another document. It may be that vendors will use this for their tools and make some kind of large conversion easier. I hope that answers your question.

Laura Frenzel: Yes, thank you.

Operator: Our next question comes from the line of Tom Hood. Your line is open.

Tom Hood: Yes, on slide 33 - under what circumstances might a physician use an underdosing code?

Pat Brooks: You know, I don’t know that I can tell you. And this may be something that came from the World Health Organization to describe that they deliberately underdosed for whatever reason. ICD-10 has this new concept, and the only time a coder would code is if a physician chose to write down that language - that “I did underdosing of whatever.” And

it is that documentation's presence, for the first time, we could actually code it. When a physician would decide to do that, I don't know.

Tom Hood: Fair answer. Thank you.

Operator: Our next question comes from the line of Denise Pullen. Your line is open.

Denise Pullen: Yes, my question is - how big of a part is our software going to have in this converting the ICD-9 to the ICD-10?

Pat Brooks: Okay, if you're talking about that you have a project where you want to convert a lot of data - say you have quality measures that you do in your hospital and you want to convert them - then you would probably use our User Guide if it's a large set. And maybe you would want to automate that yourself, and you could look at our suggestions. If you had a smaller project - a list of only say 20 or 30 codes that you personally wanted to convert and make sure you were doing it accurately - then you probably manually could use the GEMs and make that conversion, and check those in your books also. So as far as how you automate it, we think that's something that consumers like yourself would do, or perhaps vendors will automate this to make it easier. We're not sort of into developing software packages to sell it - we're only giving you the logic and the information on our web page so that you can make these decisions.

Denise Pullen: Okay, thank you.

Operator: Our next...

Ann Palmer: Christine?

Christine: Yes, ma'am?

Ann Palmer: We'll just do one more caller, please.

Operator: Okay. Our final question comes from the line of Sheila Lucas. Your line is open.

Sheila Lucas: Hello.

Ann Palmer: Hello?

Operator: Okay, we'll go on to a different one. Your last question comes from Kay Stanley. Your line is open.

Kay Stanley: Hi, there. By the way, I think you've done a great job. The...

Ann Palmer: Thank you.

Kay Stanley: When can we actually start using these codes?

Pat Brooks: Well, ICD-10-CM codes - you can only report them with services that occur on or after October 1, 2013. So in advance of that, you should use the time to get your systems updated to accept the longer codes. Or if you have something that you want to convert for your use like some large data set - you want to see what it looks like in ICD-10 - then you could start converting that now. But as far as reporting, since this is a HIPAA standard, no one can report until services occurring on or after October 1, 2013.

Kay Stanley: Thank you much.

Pat Brooks: Thank you.

Ann Palmer: Thank you for your participation. Bye.

Operator: This concludes our conference call for today. You may now disconnect your line.

END