

Centers for Medicare & Medicaid Services
ICD-10 Implementation Strategies for Physicians National Provider Call
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Introduction.....	2
Quick Review of ICD-10 Implementation.....	3
ICD-10 Implementation Strategies for Physicians (and Non-physician Practitioners)	4
Quick Review of ICD-10 Implementation (Continued)	21
Update on ICD-9-CM to ICD-10-CM Conversion of Clinical Laboratory National Coverage Determinations (NCDs) for Medicare Part B	24
National ICD-10 Implementation Issues	25
Update on bill processing, including claims that span the implementation date	27
Home Health Agency Home Health Resource Grouper (HHRG)	28
Question and Answer Session.....	29
Question and Answer Session continued.....	37

Introduction

Leah Nguyen: Hello. I am Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the ICD-10 Implementation Strategies for Physicians National Provider Call.

CMS subject matter experts will discuss ways that physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding. A question and answer session will follow the presentations.

Before we get started there are a few items I need to cover. This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Sponsored ICD-10 Teleconferences Section of the CMS ICD-10 website following this call. The website address is <http://www.cms.gov/icd10>.

There is a slide presentation for this session. If you have not already done so, this handout 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 August 3rd, 2011 call and scroll down the page to Downloads section for the slide presentation.

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 Calls. Please see slides 77 and 78 of the slide presentation for more information. If you have any questions regarding the awarding of credits for this call, please contact that organization. We encourage you to retain your presentation materials and confirmation e-mail.

We have a lot to cover today, so without further delay, we will get started. At this time, I would like to introduce our speakers who our subject matter experts on ICD-10. We are pleased to have with us Mady Hue, Health Insurance Specialist in the Center for Medicare, Hospital and Ambulatory

Policy Group; Dr. Daniel Duvall, Medical Officer in the Center for Medicare, Hospital and Ambulatory Policy Group; Lisa Eggleston, Health Insurance Specialist in the Office of Clinical Standards and Quality, Coverage and Analysis Group; Kyle Miller, Health Insurance Specialist in the Office of E-Health Standards and Services, Administrative Simplification Group; Sarah Shirey-Losso, Hospital Team Lead in the Center for Medicare, Provider Billing Group; and finally, Joan Proctor, Health Insurance Specialist in the Center for Medicare, Chronic Care Policy Group.

And now, it's my pleasure to turn the call over to our first speaker, Mady Hue, from the Center for Medicare at CMS.

Quick Review of ICD-10 Implementation

Mady Hue: Thank you, Leah. I, too, would like to welcome today's participants to the call. We have a lot to cover so I'll go ahead and get started.

Turning to slide three, we'll begin with a quick discussion of ICD-10 implementation. It's been about two and a half years now since the final rule for ICD-10 published on January 16th, 2009. One of the concerns expressed by the industry was regarding a single implementation date for all of the users that was consistent with our current code update.

As shown on the slide, October 1, 2013, is the compliance date for implementation of ICD-10-CM, the diagnoses, and ICD-10-PCS, the procedures. ICD-10-CM replaces Volumes 1 and 2 of ICD-9-CM and ICD-10-PCS replaces Volume 3 of ICD-9-CM.

On the next slide, slide four, you'll see that ICD-10-CM, the diagnoses, will be used by all providers in every health care setting. So, if you use ICD-9 now, you will switch to ICD-10. For the procedures, ICD-10-PCS, these will be used only on hospital claims for inpatient hospital procedures.

Now some of the questions that we've received in the past were regarding how to code physician's claims when they make inpatient visits and if they needed to use ICD-10-PCS. The answer is no. As you see on the third bullet,

ICD-10-PCS will not be used on physicians' claims, even for those inpatient visits.

Looking at slide five, slide five stresses the fact that there is no impact on CPT and HCPCS codes. Therefore, physicians will not be required to use ICD-10-PCS for their claims. They will still bill the same way they do now.

On slide six, we show more details regarding a single implementation date of October 1st, 2013. For reporting purposes, providers of ambulatory and physician services will use the date of service, not the date of submission. So, ambulatory and physician services provided on or after October 1st, 2013, will use ICD-10-CM diagnosis codes. Inpatient hospital claims will use the date of discharge. Therefore inpatient discharges occurring on or after October 1st, 2013, will use ICD-10-CM and ICD-10-PCS codes.

And I believe Sarah will be providing information regarding claims that span the implementation dates later on in the call.

Slide seven summarizes the key points regarding implementation. ICD-9-CM codes will not be accepted for services provided on or after October 1st, 2013. ICD-10 codes will not be accepted for services prior to October 1st, 2013. Therefore any service provided before October 1st, 2013, must be reported with ICD-9 codes.

ICD-10 Implementation Strategies for Physicians (and Non-physician Practitioners)

Daniel Duvall: What we're going to start now is basically a talk within a talk directed towards physicians. For those of you that are coders or have otherwise been involved in ICD-10 for a long time, a lot of the information that I'm going to be going over is fairly basic information and just presumably things that you already know.

But what we're hoping to do is to give you the kinds of talking points that may help you in your presentations to your physicians, your medical staff, and other people that aren't quite as familiar with the codes and coding system as you are.

So, now I'm going to start talking directly to this physician audience. Depending upon where you are and with whom you interact, there's a variety of messages floating around about this impending conversion to ICD-10, and those messages may range from an active anticipation, to calm acceptance, to outright fear and panic.

What I'm going to try to do is to provide some facts to help the practicing physicians separate rumor from reality. And, I want to take this time to point out that this applies equally well to anyone who submits standard claims to CMS, and that would include physicians, non-physician practitioners and allied health professionals. However, if I say that every time it's going to take an extra 10 minutes. So, I'm going to call everyone physician; y'all are honorary physicians for the next 30 minutes. But it's not going to change your billing; there's no manual change with it, only for ICD-10.

OK. Moving on to slide nine, the take home lessons that I'd like you to get from this are fairly straightforward. First off, I hope to show that ICD-10 is nothing more than a mature version of ICD-9. ICD-10 is inevitable. It's coming. The work for physicians, however, is negligible. It's not something to be worried about.

One of the big concerns that a lot of people have been talking about is the cost for offices, particularly where it gets into IT cost. We're going to spend a little bit of time talking about some costs- avoidable costs and reducible costs. But the basic message from this would be the ICD-10 cost of conversion for offices can be small. You can manage it.

There's a significant amount of work for institutions, but I hope that you'll walk away with the idea that the work for the institutions is completely worthwhile. And then lastly, we're going to get into the part about these conversion plans, what do you do, what should you do to think about the conversion process and prepare for it.

And that takes you to the real take-home message, that this is really something to embrace. Don't worry about postponing it. Don't try to postpone it. Look at it coming and just make some simple plans for it.

OK. Moving on to slide 10, the conversion strategy framework that CMS has applied is the same one that I would encourage you to take in your individual offices, and it's really nothing more than a general approach to problems, which is the same thing that you all use in your general approach to patient care.

If you remember, Larry Weed's S.O.A.P. notes, you have the Subjective, Objective, Assessment, and Plan. In the Subjective, you basically are getting information to define the problem and the issues. Then you move on to collect information, the Objective part. The Assessment is really involved in evaluating your options. And then finally, you do something about it, the Plan. And that's exactly the approach the CMS has consistently taken towards ICD-10 conversion, and we're going to follow that during the course of this little discussion.

So, let's talk about the Subjective, defining the problem. When a patient comes in to the office, they'll start out with something like: "I think I'm going to pass out. This feeling has been getting worse for three weeks."

In our case, "I feel an ICD conversion coming on. I noticed it a year ago. So, what do I do?" OK. What have you heard? What kinds of additional information can you give me to flesh out this problem? Have you heard that the deadline is firm? Hopefully so. This has been a very consistent message and I hope to convince you the right message that you should be hearing.

You may have heard that we're rushing over the precipice- that we came up with this idea of the conversion and now we're leaping into it in a short period of time. That's wrong. There's actually a lot of history behind this and I'll tell you some of that history, in part because I'm a history major and I still like getting into the history, but it does help show where we are today by knowing where we were in the past.

You may have heard that American health care is in serious trouble. Well, that's not a topic for conversation today, but I will let you know it's not because of ICD-9. ICD-9 is actually a fairly simple and straightforward issue.

And then the other question that comes into this is, should we be on board? There's a lot of discussion about that and you may have heard people saying yes, you may have heard them saying no. Hopefully we'll get to the point where we're all reasonably in agreement that, yes, we should all be on board.

OK. Moving on to slide 12. The Objective in the S.O.A.P. process is the fact-finding steps. So, what I'm going to do is spend a few minutes sharing what CMS has uncovered over the past – really over the past decade or longer and really where we are today.

I want to start out in the Objective discussion with a little bit of common ground and some of it's pretty straightforward. But if you're like a lot of physicians, you know a little bit- that there's ICD-9 codes out there- but not a whole lot beyond that.

So, what is ICD-10? ICD is the International Classification of Diseases, and the basic ICD-10 is the World Health list of about 2,000 diseases or what we consider to be more disease families. The ICD-10-CM is the Clinical Modification. The Clinical Modification is the U.S. version. It's an expansion of the World Health list to meet U.S. reporting needs. As opposed to the 2,000 ICD-10 codes, ICD-10-CM has about 70,000 specific codes.

And then the third term is the ICD-10-PCS; this is the Procedure Coding System. And as Mady mentioned before, this is for inpatient hospital use for coding their claims. It's not something that physicians really have to worry about. It replaces the ICD-9-CM procedure codes, but only in that one situation where they're used. CPT and HCPCS codes are unaffected and y'all can keep using those exactly as you're used to doing.

On to slide 13- the history part. The origins of ICD actually go back to about 1839 when William Farr, who was the Registrar of England, had to essentially come up with the first sort of listing and analysis of causes of death. And what he put in his first report was a comment that the advantages of a uniform nomenclature are obvious. The nomenclature is of as much importance as weights and measures in the physical sciences.

And what he's basically saying is expressed equally well by the data analysts in your offices and institutions when they say garbage in, garbage out. If you don't know exactly what you're talking about every time you use a term, you're going to get things all mixed up and you're not really going to be able to come to any conclusions.

So, we don't have to deal with terms like consumption, crisis, white plague, BCG, or pneumonia when we're talking about tuberculosis. But on the other hand, we do have our own issues. If you're thinking about severe systemic disease from bacteria in the kidneys' collecting system, what is that? Is that a UTI, pyelonephritis? Or do we call it bacteremia, septicemia, sepsis, urosepsis? Depending upon who you talk to, different people are going to be looking at the same patient and coming up with lots of different terms.

So, it's extremely important for us to have some type of system that can capture all of the nuances even as our language and our definitions of diseases evolve. And this is particularly important for those computers that I mentioned, for databases and linked medical records.

Slide 14 talks about how this proposal of William Farr evolved into the International Classification of Diseases. In 1855, we have the International Statistical Congress Classification, and that went through some tradeoffs with the French system that eventually came out in 1893 with the Classification of Causes of Death. This was getting into the first really widely accepted single list of causes of death or definitions of diseases.

And in 1898, the American Public Health Association adopted that for North American use. The importance of this is that America was on board, the United States and actually this association included Canada. North America was on board very early and has remained the driving force throughout the last century.

In 1900, this list became the International List of Causes of Death or ILCD-1 or, really, ICD-1. When that was put into place, it was put in with the realization that this was not going to be a static list and that changes were going to need to be made. So, they came up with the idea of updating it every

10 years, and that happened with pretty good regularity up until World War II came along.

The importance here is that a list of diagnoses is not static. We have to accept the fact that it's got to be changed at various points and that some change is constant. In fact, if you're close to the ICD codes, you know that the ICD-9-CM list that we use in the U.S. is updated every year. Those are small changes. They don't really make a whole lot of difference to your practice. And even for coders, most of the time the changes are absorbed very quickly.

The 10-year updates were larger than that, but still not radical changes. However, even within that framework, periodically a larger revision is required. 1948 saw what I would look to as the first 50-year revision. That was a major change. What happened then was an expansion of the code set to include morbidity. So, the numbers of diseases that are out there that don't actually kill people are still pretty significant and this was an attempt to incorporate those terms into the list.

Another tie back to the United States is that this initiative was led by Lowell Reed from Johns Hopkins here in Baltimore. And so it really was an occasion where the U.S. put a major fingerprint on this world list of diseases.

Moving on to slide 15. The process of refinement continued after that with minor changes every 10 years, until we got to about 1975. And this is where it starts becoming immediately relevant. In 1975, two things were happening. First of all, there was a significant explosion in knowledge. The numbers of diseases, the ways of describing diseases, our understanding of the pathology behind the signs and symptoms we were seeing had increased and was continuing to increase dramatically.

The second thing is that the world of 1975 was ruled by the punch card and the magnetic tape. Capturing all of this information was becoming critical. And at that time, the individuals and the organizations that were doing the revision for ICD-9 realized that the basic structure of ICD-9 wasn't going to support us into the future. It had too many constraints.

Primarily among that was a drive to expand categories; there just wasn't room in the existing system. But there were also issues with the organization of sections. The basic organization goes back into the 1850. Our knowledge of disease is a little bit different than what we had 150 years ago.

The 1975 experience started people working on the next major revision, the ICD-10. At that time, they also felt like changing the system with even a moderately significant revision every 10 years was not going to be a good idea, because these codes were penetrating too much of everyday life in the medical profession.

So, what they wanted to do was to expand that so that we had a system that was more flexible and would not require even these moderate updates more frequently than every 20 years, and that even moderate updates would be able to fit in with the existing system with minimum effort for the foreseeable future.

With that in mind, by 1993, they'd developed ICD-10. Remember we're talking about a 2013 release for our use of ICD-10 in the offices. ICD-10 at the World Health Organization level was released in 1993. This is a 20-year period. It's not a sudden jump in a year or two.

Just as a note to the future, ICD-11, if we're thinking about these 20-year iterations, is going to be built on the ICD-10 structure. So, if you don't have the foundation of ICD-10, you're diverging from the rest of the world not just for the immediate future, but for systems and reporting well into the distant future. We're carving ourselves out as an island.

OK. The other- or kind of the last significant point of this ICD-10 is that it happens to occur roughly 50 years after that last major revision. So, here again, we have a 50-year change. Trying to project that into the future, what do you expect? We tinker around with ICD-10 and sometime in around 2050, I or one of my grandchildren is going to come knocking on your door and say we're going to have to think about the next big change. If we put in ICD-10 – not if- when we put in ICD-10, we're looking at making one change and

fixing things. Relatively the equivalent of the Y2K fix for computers, we don't come back every year. We fix it once and then we're done.

OK. Moving on to slide 16. This is a quick little slide just to show you the growth of codes with these revisions of the ICD system. You can see that going from 1853 up until 1938, things were relatively flat. We had about 200 diseases that we could use. Not a lot of detail there. 1948- adding in the diseases that don't kill you knocks it up to about a thousand. That's working pretty well until we get up to here, again this is 1975, and then the final release in '93 of ICD-10, we're looking at increasing that up into the 2,000 range. Why? We know a lot more, whole lot more diseases.

So, keep in mind that ICD-6 and ICD-10 are not just annoying little tinkering with the existing processes. These are quantum jumps. They're more important than just monkeying with the system.

Slide 17, Clinical Modification. Remember that I mentioned that we use in the U.S. the Clinical Modification, ICD-CM, not the ICD itself. Why do we do that? Well, the Clinical Modification is the local expansion. They're implemented by individual countries for the use of those countries. For example, there's an ICD-CA for Canada. There's an ICD-AM for Australia. And other countries have their own Clinical Modifications.

The reason is that different countries use ICD for different things. The U.S. has the most intense data requirements of any country, and we have the largest modification. We're stuck with it or we were stuck with creating it on our own because the basic ICD doesn't have enough detail for analyzing diseases. It doesn't have enough detail for payment that we use it for. There's insufficient attention to medical encounters for reasons other than death and that gets into all of our payment systems and tracking systems.

And because of these things, we're up to that need for 70,000 codes, 16,000 for ICD-9; we're looking at 70,000 for 10. And so you might ask "why is the government trying to cram down this huge increase in codes?" The answer is the government isn't. These are your specialty societies that asked for it. Every individual specialty society was on board with needing new codes.

The ophthalmologist would say, “So he had a heart attack, big deal. It’s a heart attack. But let me tell you about all the different types of glaucoma you can have.” Cardiologists would say the same thing. “Wait a minute. No, there’re lots of different types of heart attacks, but COPD is COPD.” And you can imagine how the other groups all responded. When you put it all together, we had a need for 70,000 codes.

So, these codes were asked for by you, not by the government. And the government responded by saying, OK, we’ve got computers, we can keep track of them. You want them. You got them.

Moving on to slide 18. I’m going to show you how the ICD-9 roots and the ICD-10 roots, expand into this new system, because I’m assuming that a lot of you have seen the ICD-9 books, and probably almost as many of you have not seen anything about the ICD-10 and wonder what it looks like.

Slide 18 shows ischemic heart disease at the core ICD-9 level. On that slide, you can see that there’s five diseases. You have a myocardial infarction, or an old myocardial infarction, or angina- not a lot of detail on this one. It tells you why the patient died at a high level, but doesn’t tell you a whole lot more.

If you look at these as the ischemic heart disease categories, then move on to slide 19, ICD does let you drill down a little bit. They have some fourth digits. Within the ischemic heart disease category, they have fourth digits on the 414 other forms of chronic ischemic heart disease codes. You can specify atherosclerosis, an aneurysm, or you can specify other detail about how it’s unspecified. Again, it doesn’t help you a whole heck of a lot. There’s clearly not enough detail for U.S. payment analysis purposes. And, again, that’s where we’re really looking for.

Move on to slide 20, and you can see what the U.S. did with its ICD-9-CM. We put in that clinical detail. Here I expanded the 410 code, acute myocardial infarction. These 1,000 root codes were expanded into about 16,000 diagnoses and condition codes. With respect to the heart, it defines the heart

in regions, and identifies initial episodes of care and subsequent episodes of care.

Move on to the next slide, slide 21. ICD-10 is going to take the same basic approach. If you step back to the highest level of ICD-10, you see the chapters, which you can think of as organ systems. The chapters in ICD-10 follow the same framework as ICD-9. From a clinical standpoint, ICD-10 is just an extension of ICD-9. You see the same diseases, the same orders of diseases. You will end up seeing new code numbers. So, here at the highest level, again, the order of chapters is just like ICD-9, not a shock.

Move on to slide 22. We drill down. Within the chapter, the subdivisions look basically the same. Within the cardiovascular chapter, we can see the acute rheumatic fever, hypertensive diseases, cerebrovascular diseases, and so on. Again, looks very similar to ICD-9.

Subdivisions look the same. Ischemic heart disease is in basically the same place. What's the difference? Well, if you look on the fourth line, ischemic heart disease, the numbers in front, I20 to I25, are different than that 410 series of numbers that you saw before. Just a new series of numbers.

And if you're looking for a comparison, if you remember when license plates first went from numbers to numbers and letters, for those of you that are old enough to remember that, it was kind of a shock for people that weren't used to seeing letters on the license plates. But after the first of January, because those changes were frequently put in all at once, the cars were the same. They had the same drivers. They had the same parking spaces. They just had new license plates. And that's what's happening with this.

The diseases are the same. The order is the same. The little labels that you can use to identify them are changing.

Move on to slide 23; let's roll down a little bit further. If you look at I21, you'll notice that the acute myocardial infarction is actually labeled a little bit differently. We still have one category, myocardial infarction, but now it's called ST Elevation and non-ST Elevation myocardial infarction. It's giving

you a foreshadowing of how they're going to change things a little bit as we get in to the final detail, because if it was exactly the same, there wouldn't be any reason to make a change. It's in those fine points, those fine distinctions that the individual specialty societies wanted, that we're going to see the real benefit of ICD-10.

So, one advantage of the alphanumeric system was to allow space for better clinical grouping if necessary. You have a lot more possibilities if you use letters and numbers, exactly as you did with the license plates. The other thing, though, is that it allows us to show a better clinical grouping within the family.

So, one of the new changes that you see, I21 is actually an initial myocardial infarction. And I22 is a subsequent myocardial infarction. It's not follow-up care. It's your second heart attack.

Move on to slide 24. As you drill down even further into the I21, the ST Elevation MIs, you can see that there's some additional changes. The new grouping has moved from the old anterior lateral wall, which in 1980 was based on EKGs and made complete sense, to something that's now looking at the actual artery that's involved- left anterior descending artery. This is based on the 2010 approach, where everybody gets images. You know what arteries are actually blocked.

So, this level of clinical detail can't be captured in 9. Cardiology needed something different. And I picked cardiology because most people know at least reasonably what's going on with heart attacks, but the same arguments are true specialty by specialty.

So, the difference is down at the details. The basic structure is the same. And this really gets back to that take-home lesson that ICD-10 is just a more mature ICD-9.

In terms of ICD-10-CM from our ICD-9-CM, why do we have to go from the 16,000 to the 20,000 – I mean to the 70,000, really? Same reason that World Health Organization moved from 9 to 10. We were out of room. We had

obsolete family groups, not enough detail for computerized analysis. Exact same series of problems, particularly inadequate attention to the continuum of disease and these clinically relevant sub-steps.

In the U.S., I'm going to keep talking about ICD-10, but remember that we're almost always talking about ICD-10-CM. And the bottom line is that ICD-9-CM is inadequate to our current needs. We need ICD-10.

So, where are we in our timeframe? We are actually fairly far advanced. People who love arguing that we're jumping into it are missing the fact that this conceptualization of ICD-10 started back in 1975, and, again- we're on slide 26-CMS and other government agencies started aggressively working on our CM expansion in 1993. It was completed in 2003. Between 2003 and 2008, there was a lot of testing and public discussion. Was it done live? No, because computers have to have consistent data. We can't carve out little sections and trial this in small areas, but that doesn't mean that it wasn't tested. And that was a fairly long testing and development period.

In 2009, really end of 2008, that's where we're starting our five-year implementation period. Again, not all at once. So, we're in the homestretch of a campaign that's much longer and much more controlled than the Y2K transition.

One of the big complaints about moving to ICD-10 is the IT cost involved. Actually, a large driver of the IT cost has to do with the ability to transmit the new codes as opposed to the old ones. That's actually a separate but related issue of the 5010 conversion, which is finishing up this year. So, at this point in time, we're already committed and have already spent a large part of the IT cost. Again, we're in the homestretch for the ICD-10 conversion.

Slide 27 – but wait, there's more. This is one of those “call before midnight tomorrow and we'll throw in some extras.” It's not just that ICD-9 is inadequate, it's that there's a lot of pressure that says we really need the advantages of ICD-10.

These fall into a couple of different categories. One of them is the question of appropriate payment. I don't know how often you individually have said this to insurance companies or CMS or other agencies. I've certainly heard it a lot. My patients are sicker. We don't, though, have the ability to quantify that. You end up saying, "Wait, I should be paid more because my patients are sicker." The response from your insurer tends to be, "Well, prove it." And the answer is, "Well, I can't, but I know they're sicker."

ICD-10 gives you better ability to stratify morbidity. It has better ability to create episodes of care, which are going to be important to some of these new payment mechanisms that are coming into play. Things like Hierarchical Condition Category. Quality monitoring is going to be important. So, it's important to CMS and commercial health plans, and therefore it's going to have a significant impact on your payments, which make me say it's important to you.

It's also important in quality research and clinical trials. A lot of the issues of some of these new devices and new interventions are dealing with select subgroups. You're not talking about better outcomes in people with MI. You're talking about better outcomes in people with left-sided subendocardial MI. You have to be able to track some of these finer clinical distinctions.

It also makes for a difference in improved outcomes in population analysis. If you look at the overall cost of medical care, a lot of the arguments are not that we're spending too much, but that we're spending it in a blind fashion. We're spending money inappropriately. The ability to target our spending money and to try to get the money that we do spend to the places that it's needed requires a higher level of that analysis than we can currently do with ICD-9.

And ultimately this all comes down to the fact that 2010 computational power can't get by with a 1980's level of information. We can do a whole lot more than we could do then and we need the data to be able to do that. Garbage in, garbage out.

Next slide, 28. This is the how does it impact me? Is it worth it? What about the cost? Because, yes, there is a cost, but it's a financial cost and a cost of

effort in converting the ICD-10. And the way that I'm going to describe this is by the size of the headache. I'm rating them from the 1 headache- kind of your tension headache, up to the 5 headache problem which you could think of as encephalitis, the really bad headache. And I want to show you that from the standpoint of a physician, you're down at the 1 headache, the 1 star headache. You don't have the big worries, the big effort.

Slide 29, who's got the big headache- the 5 star, the encephalitis? That's the government. Why? What does the government have to do? It has to do what it has done over the last 20 years- that is, design a functional expansion and get it right, define the codes, change specifications in multiple processing systems, model the impact to the payment systems, update policies and tables, all of that to get these systems to work.

So, this has been a 15- to 20-year episode of work for the government with a five-year push towards the end. And one of the examples of the kind of effort that the government has done is the GEMs mapping table. It's an example of something that the government had to partly contract and partly work on directly, but then is now available for industry and other stakeholders to use.

Move on to slide 30, institutions, which I would look at as the billing agencies, the hospitals, and the health insurance plans. Those have the intermediate headaches. Health insurance plans have to do some of this payment modeling, because when we move from ICD-9 to ICD-10, you as individual providers don't want your payments to change. You don't want your cash flow to change from year to year. The insurers have to model that to make sure that doesn't happen and yes they're modeling their own cash flow at the same time. They want to make sure that it doesn't hurt them either.

Hospitals don't have quite that worry except for some of the really large systems, but they do have to change their claims submission systems and they have to pay attention to the impact in cash flow because a lot of hospital payments are ICD based. And then they have charts that have to be encoded and that's a lot of work – a lot of ongoing work. Billing agencies don't have the day-by-day work that the hospitals have; they more have work for getting

ready. They have to change their infrastructure. So, these groups have the intermediate headaches, most of which are software driven.

However, if you turn to slide 31, those institutions get to reap the institutional benefits. They get the better data, the better stratification, targeted resources, matching of payments, measurement of outcomes, all the things that I was talking about that is the social and population level benefits of ICD-10. They also get the benefit of positioning for the future. That includes things that we would look forward to over the next 10 to 15 years. Things like embedded definition, correlation with SNOMEDS for those of you that like to do that. That's on the horizon with ICD-10 as a foundation, not with ICD-9. And other enhancement that will leverage the ICD-10 framework.

This gives you flexibility. The flexibility, like Y2K, is a one-time investment. However despite the institutional cost of investment, most institutions have determined that the benefits outweigh costs of opportunities for the health care systems and the institutional players. Consider something like the automobile and the horse and buggy. You had to make the investment, but once it was there the investment pays off.

Slide 32- so what about the physician headache? The little headache, the tension headache. What does the physician have to do? He's got to pick the right code. Now, there is a slight difference between the headache for the physician and the headache for the physician office, so, let's talk about both of those.

Slide 33- for the physician, again, it has to do with picking the right code. However, I would submit to you that most physicians deal with diagnoses, not with codes. If you argue that I don't want ICD-10 to come in because I'm going to have to learn a whole bunch of new codes, ask yourself first how many ICD-9 codes do you know by heart? I can tell you that for me – and I hate to have to say this in front of people that think that I know a lot about coding- the number that I know by heart is zero. I know the index. I can look up a code when I need it. I know my diagnoses, but the codes? I don't need to use the codes.

But even if you know some, even if you use them, how many? A dozen? How long did it take you to learn the 12 cranial nerves? Not going to take you long to re-learn a dozen codes. Even if you use 30, still pretty manageable. And I would bet that there aren't too many of you that have more than 30 memorized.

So, what do you need to do for ICD-10? You need to learn how to use an index. Oh, wait, you already know how to do that and the index looks the same. So, what do you have to do? Well, you may need to create a new job aid or a new superbill for your office. You may need to look at those codes that you used most frequently in your office and put them down on a piece of paper. Six to eight hours' worth of work, familiarizing yourself with ICD-10 and looking for the codes that you actually use. So, again, I would submit, for the physician, ICD-10 is a pretty mild headache.

Moving on to slide 34, this is particularly true for the specialists. One can argue that there are diagnoses that they see repeatedly. Again, for the ophthalmologist- glaucoma, cataract, conjunctivitis, not a whole lot of things that come up over and over again. Those that you see commonly, sure, put them down on your job aid. Something like central retinal artery occlusion? You see that every day or every week? If not, look it up. Pick your top 30 yourself. So, I would say specialists have it easy.

Slide 35, what about generalists? They see the entire spectrum of disease. On the other hand, what do you see? Hypertension, diabetes, COPD. How about gout? Is that an uncommon disease? Not really. How often do you see it? Maybe once a month, once every six months, once a year? Depends on your practice, relatively uncommon. You need to know that one because you use it every day? No. Pick your top 30, pick those main ones. So, really, generalists are in no different position than the specialists.

What about office practice? How about – what's the impact on your office? Depends how big your office is. If you're part of a very large clinic, one of these huge multi-specialty clinics, then we're talking about the institution, it's a bigger headache. They've got proprietary software that they may have to fix, except that they may have already invested in that because of the 5010

conversion. They may have to talk about continuing education for their coders. Well, that's an ongoing investment. The big thing really is that software, but they get to reap the institutional benefits.

How about the medium-sized clinics? They may have to update some billing software. Again, fairly routine because most cost's not routine, it's the 5010 compliance and they have to keep their coders up to date, not huge expenses.

How about small office? A small office tends to use a billing agency. You have to pay for your next version, which most of these billing agencies are subscriptions you pay every year, so it's not a significant one time cost. What you do have to do is update your code book and you might have to update some forms. Again, not huge, and we've talked about the fact that the work for the physician is negligible.

The most important part is that you do have some flexibility. If you have an office system that's the Cadillac, that's going to be more expensive to upgrade. If you have something that's more basic, the VW, a lot less expensive. If you want dropdown lists for diseases, yes, that going to require update cost. If you're having a coder just fill in, type in the new number or the new alpha-numeric, then we're not talking about significant expense. So, you have the opportunity here to modify your costs and control your costs, so the cost for the offices can be small, it's within your control.

Slide 37, so how do you want to approach this? With a conversion plan. Your personal plan is straightforward- get an ICD-10 book, look it over, list your top 10 diagnoses and you might do that for a couple of weeks in a row. Cross off things that are atypical. List them in alphabetical order. Write the code numbers next to them. You're done. You've got your cheat sheet.

If you are responsible for an office, your conversion plan is a little bit tougher. Follow the way your diagnosis goes. It goes from physician to coder to claim. We already talked about the physician. The coder, they're going to need continuing education like they do every year. The claim needs to be 5010 compliant- need to make sure that you can put an ICD-10 code in it. If you

have an arrangement with a supplier, you need to talk to them and just get them to verify that they're taking care of that update for you.

And the important thing is the electronic medical record. If you've got one or you're getting one, you need to make sure that ICD-10 fits into it.

So, what's our conclusion? Well, there are cons. There's a downside of ICD-10 conversion. Codes – the old codes are obsolete, is that a problem? No. Your coders may be a little slower. No, not really. You can help them out with job aids. There's a cost of training- that's there every year. It's not a whole lot more. And the external system cost? 5010 is a done deal, so don't worry about that one.

The pros, we talked about those: improved third party payments, that's important to you; improved quality and performance reporting, important; better patient data groups; better clinical organization of diagnoses. And at the dollar level, if you're starting to bring in an electronic medical record, you want to convert to ICD-10 before you bring it in, not bringing one in under 9 and then convert. So, based on those things, embrace the conversion. Don't postpone it.

That gets me through to the end of the discussion for physicians. There's a couple of general references on slide 41 and those are just to go out and browse through if you're interested, and then go talk to your coders and your office managers.

Quick Review of ICD-10 Implementation continued

Mady Hue: Slide 43 mentions some of the differences between ICD-9 and ICD-10 codes. Dr. Duvall just discussed some of the examples using myocardial infarction, so I'll just follow up by stating that when you begin to focus on those diagnoses that you see repeatedly and you are reviewing the ICD-10 codes, you will immediately notice the greater details that is available such as laterality, right and left, and expanded use of the combination codes.

If you're interested in more details, there was an outreach call held on March 23, 2010 called Basic Introduction to ICD-10-CM. You can find the

information for those and other calls on the CMS Sponsored ICD-10 Teleconference's web page and the link is provided on slide 52.

Because the ICD-10 codes are longer and use more alpha characters, there will be system changes required as Dr. Duvall mentioned with 5010. Overall, the codes reflect updated terminology and modern medicine.

Slide 44 informs you of the links to the complete versions of the ICD-10 diagnoses and procedure code sets, with those annual updates of the system on our ICD-10 website. Each year when ICD-9 is updated, ICD-10 is updated also. At the Coordination and Maintenance Committee Meeting, we discussed proposed code changes and ICD-10 related updates. So, if you go to the link that's provided in the second bullet, you can find discussions from past meetings there.

Turning to slide 45, we know the tools that are available to convert ICD-9 codes to ICD-10. The General Equivalence Mappings or GEMs assist in converting data from ICD-9 to ICD-10. The GEMs contains forward and backward mappings and there's a link provided. There was also a teleconference held on May 19, 2009 titled Implementation and General Equivalence Mappings that explains in details what the GEMs are and how to use them, as well as information on the MS-DRG Conversion Project and those can also be found on the CMS-Sponsored calls link.

In terms of converting data, on slide 46, we see that the GEMs are not a substitute for learning how to code with ICD-10. You would want to use the GEMs to translate lists of codes or convert a system or application containing I-9 codes. For some small conversion projects, it might be quicker to use an ICD-10 code book instead of the GEMs. Also, if you have access to medical records, it would be more accurate.

Moving to slide 47. At the September 2009 Coordination and Maintenance Committee Meeting, commenters expressed some concerns that the annual ICD-9 and ICD-10 code updates could make transition planning difficult. So, we have received inquiries from vendors, system maintainers, and payers and they requested a code freeze.

A limited freeze was proposed in March of 2010, where we received several comments which are summarized and posted on our ICD-9-CM website and that link is on page 50 of the handout. At our September 2010 Coordination and Maintenance Committee Meeting, the final decision was announced.

Slide 48 and 49 summarize what updates will take place during the partial freeze. The last regular, annual updates to both ICD-9-CM and ICD-10 will be made on October 1st, 2011. On October 1st, 2012, there will be only limited code updates to both ICD-9 and ICD-10 code sets to capture new technology and new diseases.

On October 1st, 2013, there will be only limited code updates to ICD-10 code sets to capture new technology and new diseases.

On slide 49, you see that there will be no updates to ICD-9-CM on October 1st, 2013, as the system will no longer be HIPAA standard. Then on October 1st, 2014, regular updates to ICD-10 will begin.

Slide 50, shares the link for information on the Coordination and Maintenance Committee Meetings that I mentioned before. And the last few slides provide links to our CMS resources. For ICD-10 general information, you can go to that website. You will find long and abbreviated code titles that are available on ICD-10-CM as well as other files. Also, with regards to system changes with the 5010, there were provider calls held in June and September of 2010 titled ICD-10 Implementation in a 5010 Environment and you can find information on those with that link.

On slide 52, we give the main CMS ICD-10 website once again, as well as the ICD-10 Teleconference web page where you can find materials such as with today's call, from past presentations with slides and audio podcasts.

On slide 53, we have additional provider resources such as the Medicare Fee-For-Service provider resources and if you go there you could find MLN Matters Articles. Under Provider Resources, you can find fact sheets such as ICD-10 Basics for Medical Practices.

Slide 54 shows sites where you can obtain additional ICD-10 resources. Both WEDI and HIMSS, they offer provider resources such as a vendor resource directory and various tools including assessments and worksheets

Update on ICD-9-CM to ICD-10-CM Conversion of Clinical Laboratory National Coverage Determinations (NCDs) for Medicare Part B

Lisa Eggleston: As you heard Leah say, my name is Lisa Eggleston. I worked for CMS within the Coverage and Analysis group and the Office of Clinical Standards and Quality. My colleague, Dr. Jeff Roche, who's not here today, as well as myself, together with other CMS staff and our expert contractors, have been working on the ICD-10 conversion of Clinical Laboratory Services that are currently covered by Medicare Part B, and today I'd like to briefly update you on what we've accomplished and what lies ahead.

Slide 56 talks what we've done so far and what remains to be done, but I would like to emphasize we will not be releasing any ICD-10 versions of the Clinical Labs Services coverage policies at this time, and we're not at this time announcing any expected date on which CMS will post such updates. However, we can suggest that you check the CMS ICD-10 web pages, and the web page has been noted a number of times and will be noted at the end of my presentation, for more information as when it becomes available.

So, let's go ahead and summarize the work so far on slide 57. We have learned to use the General Equivalence Mappings, or the GEM files, as you heard Dr. Duvall talk about within his presentation, as well as Mady. CMS has posted the GEM files and documentations – and documented their use at the [cms.gov/ICD10](https://www.cms.gov/ICD10) website.

Second, we used the GEM files to convert ICD-9 codes in most of the current lab service coverage policies. This can be done manually, especially since there are relatively few ICD-9 GEM codes. However, we found that for our needs, we were able to use an off-the-shelf, commercially-available database program for desktop computers, and so far we've converted thousands of ICD-9 GEM codes that are currently included in Medicare Part B coverage policies for Clinical Laboratory Services. However, this part of the project is definitely ongoing.

Slide 58, it continues with what we've done so far. And we really want to acknowledge all of the help that we have received from other CMS staff as well as the subject experts at our Medicare Contractors, as well as other contractors that we have been utilizing who have kept us on the right track.

Finally, and we covered this in detail during our May 18th CMS ICD-10 conference call, Jeff and I explained how the conversion process works for us for our lab projects and some of the choices that we made along the way, and if you care to look at that presentation, you can download those slides from the ICD-10 web page to find out more.

Slide 59 briefly talks about what remains to be done. We will continue our conversion of our lab NCDs over the coming months, particularly as ICD-9 codes and ICD-10 codes continue to be updated as Mady talked about in her comments. And we will incorporate these ICD-10-CM converted versions into CMS system modules.

For slide 60, we will also continue to coordinate our work with other ICD-10 CM conversion efforts within CMS. This will include periodic updates for Pat Brooks and Mady Hue and the rest of the folks on that team. And, finally, because there were many listeners on May 18th who had questions about it, I just want to emphasize that at this time we are not releasing any I-10 conversions of the clinical labs service coverage policies, and we don't have an expected date when that will come, and just want to re-emphasize to check the I-10 web pages for more details as it becomes available.

National ICD-10 Implementation Issues

Kyle Miller: Thank you, Leah, and we'll go ahead and get started on slide 63, with the implementation date, which everyone knows is October 1st of 2013. And of course there will be no delays, and, again, repeat, there will be no delays.

CMS does not intend to delay Version 5010 or ICD-10 implementation. And, as so, Version 5010 and ICD-10 are both foundational to other health care initiatives, including meaningful use of electronic health records, and the adoption of additional standards and operating rules for electronic health care

transactions under the Affordable Care Act. All of us here at CMS are committed to meeting these regulatory compliance deadlines, and we expect the industry to do the same.

So, on to slide 64, paper claims. Providers can use paper to submit their claims to payers for reimbursement payments. As we all know, HIPAA requirements only apply to electronic transactions. But CMS will require ICD-10 on all claim submissions, electronic or paper. I will re-emphasize that CMS will require ICD-10 on all claim submissions, electronic or paper.

On the UB-04 hospital paper claim form, also known as a Form CMS-1450, it has been upgraded to accommodate the ICD-10 codes. The National Uniform Claim Committee recently closed a public comment period on July 21st for revisions to the CMS-1500 Form. And, from a practical standpoint, overall, the industry, both covered and non-covered entities, are all migrating towards ICD-10.

So, moving on to the transition to ICD-10 for state Medicaid agencies on slide 65. As of this July, we have 11 states that are at a high risk for meeting the implementation date. We have 21 states that are at a moderate risk, 15 at a low risk, and 4 that did not respond to our readiness assessment in July. And I think it's important to remember, though, that there's still two years to go, and within that time here at CMS, the Center for Medicaid, CHIP, and Survey and Certifications is working with each of those states that we've identified is having a risk, to help mitigate that risk and develop strategies for doing so.

So, moving on to slide 66, concerning non-HIPAA covered entities. Per the National Committee on Vital and Health Statistics testimony, many non-covered entities such as workers comp, property and casualty, as well as others, are all apparently working towards ICD-10. And they have been over the past couple of months requesting information from CMS regarding ICD-10, as well as conducting research into the implications for their business processes and systems.

So, on to the Version 5010 schedule and impact on ICD-10, on slide 67. As of right now Version 5010 Medicare Fee-For-Service claims are already being

accepted in full production mode, and tests indicate that we're having very few problems with those. CMS is actively preparing its business processes and systems for the ICD-10 transition, which is coming along quite well.

And as far as the industry is concerned, there needs to be testing often, specifically for 5010 at this point. And folks want to be checking with their vendors concerning when ICD-10 software is available to ensure that you do meet the compliance date of October 1st, 2013.

Update on bill processing, including claims that span the implementation date

Sarah Shirey-Losso: Hello, and please refer to slides 69 through 71 for the highlights of what I'll be talking about for the next couple of minutes. I know there's been a lot of interest in this topic, and I wanted to give everyone an update of where the Medicare Fee-For-Service side of CMS is in terms of how we will handle claims that cross over the October 1st, 2013 implementation date of ICD-10.

We are actually very, very close to finalizing our decisions for all claim types. This includes professional, supplier, and the various types of institutional claims. Some claims will continue to use the from date; some dates will continue to use the discharge and/or through date; and some claims will be required to be split over the October 1st date.

CMS is anticipating the release of a Change Request discussing how Medicare Fee-For-Service will be handling the various claim types very shortly, hopefully by the end of this month. This Change Request will also address various questions we've received thus far. One example being how will professional claims be billed for anesthesia procedures that begin at 10 P.M. on September 30th, 2013, and end at 2:00 A.M. on October 1st, 2013? These and other questions will be addressed.

In addition, I want you to know that we are actively working on the various internal changes to our Fee-For-Service claims processing systems. This includes very technical items, such as expanding field sizes and screens to accept ICD-10 codes, to the loading of a master ICD-10 file into our system to validate codes, to updating various edits and modules to ensure that your claims will pay the same as it did pre-ICD-10.

So, with that, I want to thank you for your attention, and more to come in the very near future.

Home Health Agency Home Health Resource Grouper (HHRG)

Joan Proctor: Hi. This is Joan Proctor, and I'm going to be presenting on the Home Health Agency Home Health Resource Grouper that we maintain. I am speaking from slide 72. I will be the point of contact going forward on the Home Health Resource Grouper for ICD-10 .

On slide 73 - On July 12th, 2011 CMS released our proposed rule. In our proposed rule, there is information pertaining to our transition to ICD-10. There is the URL, which you can go in and access and take a look at. If you have any public comments, there is a deadline of September 6th on which you can electronically or through hard copy submit your comments on that proposed rule.

We cannot discuss the proposed rule at this time. However, we did want to make the provider community aware that it is out there for public review.

Moving on to slide 74. After the call that we had on May 18th, the National Provider Call on ICD-10, some follow up questions were submitted to CMS. I want to reiterate our response in this forum so that everyone has the answer to those questions in case others have similar questions and were not able to participate.

One of the questions posed was whether or not CMS plans to post the translation lists in a format similar to that outlined for the Lab NCDs, and the answer at this time is we don't know. We have not reached a decision regarding the format. As soon as we do have information pertaining to the format and the proposed lists, we will be posting information on the ICD-10 section of the CMS website so that everyone has an opportunity to review our plans.

One of the other things that I would like to announce at this time is that during the May 18th call we had suggested October 2011 as the date in which we project that we may be able to post our list of ICD-10 codes for the Home

Health Agencies Resource Grouper. At this time, that looks unlikely. Based upon the experiences that we're having thus far, we think that it will be delayed. However, there will be sufficient time for the provider community to take a look at these codes prior to the release of next year's rule and to be able to review and provide us with their feedback.

Moving on to slide 75. CMS does plan to provide more detailed information in next year's 2012 rule regarding those home health ICD-9 – ICD-10 codes that we would be transitioning to and allow public comment and feedback.

Question and Answer Session

Marcella Jones: OK, we're from Health Partners Home Health Care, and we just tried to go to the proposed rule text, the site for that that's given, and it's says content unavailable. Is this not the correct address or is it not available?

Leah Nguyen: It must be not available, because I happened to check it earlier and it was working fine.

Joan Proctor: Yes. There are times in which there are things going on that you will find sometimes you'll get that. However, two hours ago I was able to go on and access it. So, any additional information I'll be glad to follow up with you.

Elizabeth Zappa: Hi. This is Liz from 1199 Benefits Fund, and I believe during your May teleconference you talked about doing a readiness survey and expanding it to 120 providers and health plans, and I was wondering if that was completed and when the outcome results would be available to the public.

Leah Nguyen: Hold on one moment.

Leah Nguyen: Hello. This is Leah Nguyen. We don't have the correct date in front of us, If you could go ahead and submit your question to our resource box that's listed on – I believe it's slide 80- and just go ahead and put that in the subject field, then we can get back to you.

Louise Cheher: Thank you very much. Good afternoon.

Just a quick question on slide 65, where's it's dealing with the transition for Medicaid. How do we find out if our state is one of the high risk or moderate risk?

Kyle Miller: If you submit that also to the box, I could provide you with the link that you can go to where there's an interactive map.

Louise Cheher: OK.

Kyle Miller: And you can look at your respective state.

Louise Cheher: That would be great. Thank you.

Kyle Miller: No problem.

Operator: Your next question comes from the line of Madden Brassard. Your line is open.

Madden Brassard: Yes. The question is how much the economical impact will be on solo practitioners? I mean, after converting the ICD-10.

Dr. Daniel Duvall: Right. The economic impact again depends on exactly how your office is set up. In terms of payment, it doesn't make any difference to payments for solo practitioners or for practitioners at all. From the standpoint of office investment, it depends on really how much IT involvement your office has. If you're talking about from the bottom end of the solo practitioner where you actually submit paper claims, it involves getting a new coding book and getting some new paper claim forms.

As you go up from there, for most claim submission systems, it's going to depend on the individual supplier that you've got as to how they're pricing their systems from year to year. They do have a development cost in terms of updating their system, but, again, these are systems that are generally being continuously updated anyway.

The significant financial impact comes in those practitioners that have made a significant IT investment into some type of a customized system and even

there it depends on exactly how the system was customized. So, for most solo practitioners, it should be small but it's not a guarantee. You have to look at exactly what your IT footprint is.

Madden Brassard: If you are using electronic billing?

Dr. Daniel Duvall: Right. Again, using electronic billing, there are certain types of free software for electronic billing- that's going to have no financial impact on you. If you're using something that you're purchasing from someone, you might see an increase in their rates from one year to the next or you may not. It all depends on how they fit their development cost into their year-to-year pricing schemes.

So, again, it should not be large. If it is, you need to talk to your supplier and talk to his competitors.

Loretta Shepherd: You say that it's not going to be much expense for the office other than just getting the code or looking the codes up. Our concern is the requirement now from insurance companies to prove these new codes and the cost of transmittal of additional information. Has that even been looked at with this?

And, also, with the way that our Medicare costs are skyrocketing, is the amount that our government and their encephalitis headache having to pay for this system worth the amount of money it's costing the American public?

Dr. Daniel Duvall: Let me answer those questions in reverse order. This is Dan Duvall.

In terms of the benefit for the cost of this encephalitis headache, absolutely. This is me speaking both, I think, officially as CMS but also personally, just in terms of my own evaluation, both from what I've seen at CMS and from my experience in the industry before coming to work for the government. The ability to do the more sophisticated data processing and data analysis is critical, and the expected pay offs both at the government level and at individual institutional levels is pretty significant.

Moving on to the second part of your question, or the first part of your question, about proving the codes- I'm not sure exactly how you mean that the

insurance companies are wanting you to prove the codes. The coding requirements under ICD-10 are no different than they are under ICD-9. The code that you use reflects the actual clinical circumstances of the claim.

Now, from the standpoint – one of the worries of the insurance companies is making sure that their aggregate payments aren't going to change when the system moves from 9 to 10. That's their worry, not the individual provider worry. So, that's not something that they should be passing on or that they really even can pass on to provider offices.

Loretta Shepherd: Well, it's been our – what we've had to deal with is that any time there's a code change, they require us then to produce all the records so that they can look at all the records to show that we're using the proper code and to prove that the code that we're using is the appropriate code for that particular patient.

And we've been on EMR now for almost 2 ½ years, and every time we have a code change we have an overwhelming need to send additional records to prove to the insurance companies that what we're listing in our claims is accurate. And it takes so much time for our employees, you know, having to do that on an ongoing basis. And time for the doctors to have to review those records before they go out.

Dr. Daniel Duvall: Got it. I understand what you're talking about. That's not the same issue that we're going to have with moving from ICD-9 to ICD-10.

Now, the individual commercial insurers- and actually Medicare Fiscal Intermediaries or the MACs and anyone that's receiving claims- are going to have questions about whether claims are correctly coded, but we're actually now talking about every single claim that comes into them. So, it's not an issue of focusing on particular providers and looking at either recoding of individual claims or of using new codes correctly when a couple of new codes come out.

Because this is global, you can't have an across-the-board approach of saying I'm going to need to look at everything. It is unachievable from an insurance

company standpoint. So, that would be a worry that I would push aside. In some sense, moving from 9 to 10 is putting everybody back at the starting gate, Everyone's starting evenly, so you may even find this to be an advantage.

Bill Singletery: Thank you. I have a question for Dr. Duvall. I enjoyed your presentation very much, but one of the messages I was hoping to hear as you were discussing the impact on physicians in achieving appropriate payment and proper stratification of morbidity was the importance of higher specificity in physician documentation. And I think ultimately that is what's going to drive accuracy in coding and provide the audit defensibility and appropriate payment that is needed.

Could you please speak to that?

Dr. Daniel Duvall: Sure. This is Dan Duvall. I agree 100 percent and although it's not quite related to ICD-10, it makes a great Medlearn topic, and in fact actually is a Medlearn topic that I was writing on a little bit earlier today.

So, this is an ongoing issue, and it is equally important under 10, if not more important under 10. Coders cannot code what's not in the claim- what's not in the medical record. Sorry. And as you find that there are more gradations of codes, more opportunities for coders to pick from a list, they're going to be coming back to physicians early on a little bit more at the beginning to say, wait, I need more definition to help me pick A or B.

Now, ICD-10 has some less specific options, but as you use the less specific options, you lose the ability to do that sophisticated data analysis, the sophisticated stratification. So, the message that I would expand on, starting from your message, is not only is it important for physicians to be more specific in their codes – in their medical record documentation, but this is an opportunity to enlist their coding staff to move away from the comfortable position where they're in of, oh, yes, I know exactly what Dr. Smith is thinking, so I can write it down even though his medical record just says “looking well,” and move to a, “Dr. Smith, can you give me a little bit more information, document it to help me select my code?”

And that's going to give you a medical record that is going to stand up a lot better to audit and hopefully be better from a patient care standpoint. Because remember what we're really looking for in this information is not the payment. The payment's important, but what we're looking at is this electronic health record idea where what you write down is going to be shared with a lot of other doctors.

Speaking as an E.R. doctor, when I have access to an electronic medical record and pull up somebody's office notes, if all it says is unchanged, I haven't learned anything. But if your coder's pushing you for that more specific information to help their coding, that's going to give me more information and hopefully have better patient care come out as well.

So, great point.

Jackie Kravitz: Thank you. I actually have two questions, as I was listening to everybody else's I thought of one. I apologize. But the first one is with two years to go and with the high learning curve that we have, when do you suggest sending coders to start their CEUs, to understand exactly how ICD-10 works?

And also, my second question is how does the government plan to pay for this ICD-10 coding debacle, because 30 percent of our cost reduction that was just voted on by our government is coming from Medicare?

Mady Hue: This is Mady Hue. I'll answer your first question regarding coder training.

In previous calls and today, I would still recommend that you seek training no more than six to nine months prior to the implementation date for ICD-10.

Jackie Kravitz: No more than six to nine months?

Mady Hue: Correct, because...

Jackie Kravitz: OK.

Mady Hue: ... as I discussed, we're in partial code freeze and over the next couple of years there is the possibility that we could have new technology or new diseases, new procedure codes and new diagnosis codes. So, the current code set that's out there are still consider draft form.

Jackie Kravitz: Thank you.

Mady Hue: You're welcome.

For the second question, I would recommend submitting that to the providers' box on slide 80 that was linked.

Jackie Kravitz: Yes. Well, thank you very much.

Mady Hue: You're welcome.

Operator: Your next question comes from the line of Natasha Cooks. Your line is open.

Natasha Cooks: Yes. With regard to the laboratory NCDs, is it seen as an intention to provide the ICD-9/ICD-10 conversion with enough time for the industry to comply with it? And the follow up to that will be, will CMS impose a similar timeline for the MACs to publish the LCD counterpart?

Lisa Eggleston: Hi. This is Lisa Eggleston. As I had said in my comments, because it came up quite often on the May 18th call, I wish I could say we're going to post it on blank, blank, blank date, but I can't right now. But as soon as we can, we'll make sure that that information is available on the I-10 website. But, you know, our goal would be to make sure that industry has enough time for their purposes as well.

Marcie Case: Hi. One of the comments was that we should bring in ICD-10 now, and I'm just wondering how you can do that when it's two years away?

Mady Hue: Hi. This is Mady Hue. Could you elaborate a little bit about what you mean by bring in ICD-10?

Marcie Case: Well, we were on page 40 and Dr. Duvall said it would be a good idea to bring in ICD-10 now. We were talking about improving third – the pros were improving third party payments, improving quality in performance, and he said it would be a good idea to bring it in now, and my question was how can we bring it in now?

Dr. Daniel Duvall: This is Dan Duvall. I can answer that one.

Actually, it would be great if we could bring it in now from a data standpoint. I would love to have the data that I could find in the 10 codes at my fingertips when I'm trying to analyze things.

What I was actually talking about was bring it in now as in the timeline that we're currently on, because there are some people out there that's still talking about, well, can't we postpone this until, you know, 2020, 2050, God knows when? And the – my point really is, no, we're well down the pathway with a cut over point in 2013, and my recommendation is let's keep on that pathway and – I mean, and certainly CMS is going that pathway- but everyone else, should emotionally be on that pathway with the idea of, yes, we want it as soon as we can, and that's going to be October 2013.

Marcie Case: So, it's not physically bringing it in now but emotionally we should be starting to do some kind of conversion and stuff like that?

Dr. Daniel Duvall: Exactly.

Marcie Case: ...conversion on paper, but not bring it actually to our computers or anything like that.

Dr. Daniel Duvall: Right. You should be talking with your suppliers, talking with your computer people, making sure that you're thinking about it. And the closer that we get to 2013, the more you should be thinking.

You don't want to wait until 2013 and think about it for the first time then.
But...

Marcie Case: Oh, no. .

Dr. Daniel Duvall: ... you're not bringing it in today.

Marcie Case: OK. OK, I just – I misunderstood that. OK, thank you.

Question and Answer Session continued

Operator: Your next question comes from the line of Sherrie Burkham. Your line is open.

Sherrie Burkham: Hi. My name is Sherrie Burkham. I'm with Amarillo Colon and Rectal.

We – I have a question about the inpatient codes, because we do inpatient surgeries, and are those codes going to change?

Mady Hue: Yes. This is Mady Hue. In my review, I went over that for inpatient the diagnoses codes for ICD-10 are ICD-10-CM. And for the inpatient procedure codes, those will be ICD-10-PCS.

If you go to the links that were provided on the resources slide, we have the draft complete codes for both diagnoses and procedures on our website. So, I would encourage you to go out there and you can take a look. And ...

Sherrie Burkham: OK, what is it that I go to? I'm sorry.

Mady Hue: There's the link on the resources page, but I can go ahead and just give you the website.

Sherrie Burkham: OK. Thank you.

Mady Hue: www.cms.gov/ICD10. And there you would look for the ICD-10-PCS and GEMs files, and then also the ICD-10-CM and GEMs files. And there you'll find the code descriptions, the code titles. You'll find the tables and the index, the reference manual slides, so there's lots of resources out there.

Sherrie Burkham: Oh, good. Thank you so much.

Mady Hue: You're welcome.

Sherrie Burkham: Yes.

Operator: Your next question comes from the line of Susan Wertz. Your line is open.

Susan Wertz: Hi. Thanks for taking my call.

A question regarding the documentation or creating of a job aid. Superbills, I don't see superbills being able to be used in the future, as far as ICD-10, only because of the specificity that's going to be required. The – I guess the biggest thing that I'm dealing with is the comment regarding that the physicians or even small practices really aren't going to be impacted by this a whole lot.

When I look at documentation and there's no specificity that's going to be paid by the payers and, you know, with the lack of detail. And I do have a good, solid grasp of ICD-10, and I've actually already started to do my own internal audits. You know, I just – I don't understand where this is coming from with the small positions to – or physicians to just be don't worry about it and continue documenting the way that you're documenting, which has always been an issue from a coder's standpoint to begin with.

Dr. Daniel Duvall: This is Dan Duvall.

The answer is not to continue to document the way that you've always done it in the sense that if your documentation has always been inadequate, then don't keep doing that. But for physicians whose documentation has been detailed, which is what you should expect from physician documentation, then what they need to continue to do is to document adequately, and the coding derived from the documentation.

So, are there some things that they – that the coders will have to go back and do different, you know, interact with the physicians? Yes. That was what we were talking about. It's an opportunity to improve the documentation.

Is that true? It depends on the offices. I've looked at a lot of different office medical records, and there are a lot of them where you have physicians that

are used to documenting extensively and they won't need to do anything differently. The ones that sort of like ones that I was talking about where all you saw was a blank piece of paper that said patient's doing well? Well, they have to do something different, but that's not really because of ICD-10. They need to be doing that differently anyway.

Susan Wertz: I agree that they need to be doing it differently anyway, but ICD-9 allows them to go with less specificity than ICD-10 will, and you've got a lot of physicians out there that really don't believe that this is going to impact them very much. Therefore, their documentation is just what they need to get by.

When we look at what the payers – looking at the payer policies that are going to go into place with the specifications- of a specificity – excuse me – that's coming into play with ICD-10, how do we – you know, your point is saying to the doctor, this is, you know, just a tension headache, but I see this more as a migraine – very much a migraine with physicians that are just coding, just documenting enough to just get by and how that's going to impact their coders.

You know, you talk about, you know, diabetes codes, and looking at that. Well, there's 250 choices in ICD-10 for diabetic codes alone.

Dr. Daniel Duvall: That's true. So, there's considerable variation as you move from specialty to specialty. And, again, going back to that one comment that I made that it was actually the physicians within the specialties that wanted this additional ability to drill down into detail.

Now, there are ways even within ICD-10 of handling records that are not coded- that are not documented fully. So, if you are stuck with one of these physicians who's just about to retire and there's no way you're going to change his documentation because he's been doing it that way for the last 45 years, there's – you can still code that under ICD-10. You lose information, so we don't want to encourage that, but you actually don't have to force him to do something different in order to be able to code the claim under 10. However, you've got the opportunity again to improve it.

And the number of new choices that you have depends on the diseases that the physician is dealing with. If you take diabetes, for example, those – the information that you need to code from those 250 choices is still usually in the medical record, but it's not in the same places that you're used to seeing it, which means that your opportunity for the office – you have two opportunities or two options.

One option is you just say, well, we take the record that comes to us and we go through it and we try to pull out which one of those 250 we pick. If you do that, your rate of coding is going to drop off precipitously. It's going to take you a lot longer to code individual claims.

On the other hand, if your doc is seeing a lot of diabetes and you work with him with getting back to that superbill or the list of common diagnoses concept of, OK, what do you see most often – the most often? What subconditions or what information can you put down that will help me pick which of the five of those 250 that I'm going to be using most often? Because it is going to be a small subset of them. You're not going to be equally distributed across the 250.

That's the opportunity that's going to let you increase the – improve his documentation, not really impacting him. He doesn't have to think about ICD-10 to do this. He just has to think a little bit about where -helping you to find where the information is. But that's also going to help your coding and make sure that you don't have that significant drop off in rate of coding when you switch over.

Susan Wertz: I guess what I'm really looking for is, you know, what I heard I guess coming out and listening to this was saying, you know, physician participation isn't going to have to be very large. So even in such as, you know, the specificity in the MIs with the ST versus non-ST, the non-ST levels, that has to be documented in order to code appropriately in ICD-10, where they don't necessarily need to have it now.

The physician education that needs to go on is a lot bigger than I think people realize as far as that documentation is concerned to make sure that it is

documented. And I understand what you're saying. By taking your top 30, I would actually look at a little bit more than 30 codes, but then the practice and especially if you're dealing at a family practice or a general practice, I think they're going to get hit the hardest on this just because of the code selection that's there.

Dr. Daniel Duvall: Yes. I mean, there's – those are good points, and I think it's fair to say that one could look at it that it's going to take you five or 10 years to really train your physicians well to document what you need, except for the fact that if you look at our current crop of physicians, me included, can you really say that you've trained us well? The answer is no. So, it's an ongoing effort.

It's the same battle you're fighting with the existing ICD-9. You're going to continue to be fighting it in ICD-10. But you're right. It's going to require work with the physician.

Susan Wertz: Yes. And then there's going to be a cost to the physician, small or large, if that documentation is not going to be there for the specificity that's going to be required by the payer to get that claim paid.

Troy Mayer: Hi. Just a couple of quick questions.

One quick question is the updates for the new codes, in what format will they be? And how will we be able to get them?

Mady Hue: OK, this is Mady Hue, and are you talking about the diagnosis codes, procedure codes?

Troy Mayer: Yes. Actually, will they be – let's see – in a PDF? Will we be able to get them at an – let's see – an XML file...?

Mady Hue: If you go out to the website that I listed on the slide and as mentioned earlier, the [cms.gov/ICD10](https://www.cms.gov/ICD10).

Troy Mayer: Right.

Mady Hue: You'll see the files that are currently out there.

Troy Mayer: I see the PDF files, but I was under the impression there might be other formats that you have.

Mady Hue: So, the formats that are out there currently are the ones that are available.

Troy Mayer: OK.

Mady Hue: If you are requesting a specific format, you could submit that to the – that box, the ICD-10 mailbox.

Troy Mayer: OK.

Leah Nguyen: On slide 80.

Mady Hue: On slide 80.

Troy Mayer: OK.

Mady Hue: Otherwise, the ones that I'm aware of are the HTML and text files.

Troy Mayer: OK. Yes, so the text file and HTML. OK.

And just one very quick one is will there – well, actually your last caller talked about the specificity issue, so I'm assuming that there will be a certain specificity that's necessary for any kind of payments.

Mady Hue: I won't speak to the payment aspect, but for the codes themselves, as Dr. Duvall indicated, there are codes available for the unspecified conditions if the physician's documents are less specific.

Troy Mayer: OK.

Dr. Daniel Duvall: This is Dan Duvall. Let me remind you that for most claims other than the inpatient hospital claims and some of the similar types of claims in other environments like home health and things like that, the – it's not the ICD code

that drives the diagnosis. So, for a lot of claims, it's- you're looking at other elements of the claim.

Troy Mayer: OK. Thank you very much.

Leah Nguyen: Jessica, it looks like we have time for one final question.

Operator: Your final question comes from the line of Steven Dion. Your line is open.

Steven Dion: Yes. Thank you.

We have a question related to the overall sort of private payer loop of organizations out there, the Aetnas, the Uniteds, et cetera. Do you all have a sense as to what translation mechanism this sector is planning on using for ICD-10? Do you have a sense as to whether the GEMs file is what they're using as a rule or any – if there's any knowledge on this topic at all?

Leah Nguyen: Hold on for one second.

Dr. Daniel Duvall: This is Dan Duvall. The GEMs is available, and it's the starting point that by and large most areas of the industry are using. That doesn't mean that they're adopting it exactly as it is, and because even the GEMs as written gives you a framework but doesn't help you on a case-by-case basis. So, you can look at it as variations of the GEMs, but even if you started from scratch you would still end up with something that looks pretty similar to the GEMs.

Leah Nguyen: Unfortunately, that is all the time we have for questions today.

Before we end this call, for the benefit of those who may have joined the call late, please note 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 Calls. Please see slides 77 and 78 of the slide presentation for more details.

Also, if you are interested in being notified when ICD-10 announcements are made by CMS or when new material is posted to the ICD-10 website, you can

register for two e-mail notification services: CMS ICD-10 Industry E-mail Updates and the ICD-10 Latest News Page Watch. Links to these resources and registration instructions are located on slide 79.

We would like to thank everyone for participating in this CMS ICD-10 Implementation Strategies for Physicians National Provider Call. 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.

I would like to thank our speakers Mady Hue, Dr. Daniel Duvall, Lisa Eggleston, Kyle Miller, Sarah Shirey-Losso, and Joan Proctor for their participation. Have a great day everyone.

END