

Centers for Medicare & Medicaid Services
ICD-10 Implementation Strategies for Physicians National Provider Call
Moderator: Leah Nguyen
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1:00 p.m. ET

Part 1 of 4 Audio Recordings

Welcome and Implementation Strategies for Physicians

Introduction

Leah Nguyen: Welcome to the first of four podcasts from the National Provider Call on ICD-10 Implementation Strategies for Physicians. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, August 3, 2011.

The first podcast features presentations by Mady Hue and Dr. Daniel Duvall from the Hospital and Ambulatory Policy Group on national ICD-10 implementation and ICD-10 implementation strategies for physicians.

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.

Leah Nguyen: Thank you for listening to this ICD-10 national provider education podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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