

ICD-10 Implementation Strategies and Planning National Provider Call

Moderator: Leah Nguyen

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only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

Operator: Welcome to the ICD-10 Implementation Strategies and Planning National Provider Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for participation in today's call. I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

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 and Planning National Provider Call. This call will feature presentations by representatives from the ICD-9-CM and ICD-10 Cooperating Parties: CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the Centers for Disease Control and Prevention (CDC). (Please note that CMS does not endorse outside organizations' materials or activities.)

CMS subject-matter experts will also discuss the Medicare Fee-for-Service Claims Processing Guidance issued in August 2011, which includes information about claims that span the implementation date.

A question and answer session will follow the presentation.

Before we get started, there are few items I need to cover. This call is being recorded and transcribed, and 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.

There are two handouts for this session, a slide presentation and a Medicare Learning Network (MLN) Matters article. If you have not already done so, these handouts may be downloaded now from the CMS ICD-10 Web site, located at www.cms.gov/ICD10. At the left side of the webpage, select CMS

Sponsored ICD 10 Teleconferences, then select the November 17, 2011, call, and scroll down the page to the Downloads section for these materials.

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. See slides 89 and 90 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. Now it is my pleasure to turn the call over to our first speaker, Pat Brooks, Senior Technical Advisor in the Center for Medicare, Hospital and Ambulatory Policy Group. She will cover general ICD-10 requirements and CMS implementation planning.

General ICD-10 Requirements and CMS Implementation Planning

Pat Brooks: Thank you. We'll begin with slide 4. October 1, 2013, is the compliance date for the implementation of Version 10 of the International Classification of Diseases for diagnoses (ICD-10-CM) and for procedures (ICD-10-PCS). This is a firm implementation date, and there will be no delay. I'm now going to ask Elizabeth Reed, who is on the phone from the Centers for Medicaid and CHIP Services, to comment on Medicaid's plan and their implementation dates.

Elizabeth Reed: Thank you, Pat. Good afternoon. My name is Elizabeth Reed, and I work in the Division of State Systems here at CMS. My responsibility is to provide oversight and technical assistance to States for the 5010 NCPDP and ICD-10 implementations for their systems.

There has been no change in the implementation dates for 5010 NCPDP, which is still January 1, 2012, or the ICD-10, which is still October 1, 2013. There have been no waivers granted, and if States are not in compliance by the implementation dates, complaints may be filed against them.

I can tell you that most States are still conducting impact analyses and gathering business requirements for the changes needed to accommodate the implementation of ICD-10. CMS currently conducts biweekly calls with the States and is currently offering State-specific technical assistance training.

I encourage providers to get on their respective States' listservs to stay in tune with any communications and testing requirements. Provider readiness and cooperation will be an integral part of the end-to-end testing for payers.

Now I will turn the call back to Pat.

Pat Brooks: We'll go now to slide 5, where you'll see that the ICD-10-CM diagnoses will be used by all providers in every health care setting. ICD-10-PCS, the procedure part of ICD-10, will only be used for hospital claims for inpatient hospital procedures. ICD-10-PCS will not be used on physician claims, even those for inpatient visits.

On slide 6, you will see there is no impact on CPT or HCPCS coding. They will continue to be used as they are now.

Slide 7 shows that we have a single implementation date of October 1, 2013, for all users. The date of service for ambulatory and physician reporting is the date that will determine when ICD-10 will be used. Services provided on or after October 1, 2013, will use ICD-10-CM diagnosis codes. The date of discharge will determine the implementation date for hospital claims in inpatient settings.

On slide 8, we see that ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013, and ICD-10 codes will not be accepted for services provided before October 1, 2013.

Slide 9 notes that CMS is in the process of converting its payment systems and edits from ICD-9-CM to ICD-10. CMS will not maintain ICD-9-based payments and edits for services provided on or after October 1, 2013.

Slide 10 refers you to websites where you can get additional information about some of our efforts within CMS to convert our payment system. Here you will find a link for the MS-DRG conversion as well as a link for the Lab Coverage Decision conversion.

Slide 11 provides a link for information on home health conversion efforts, which we covered in a prior call. On slide 12, there's a link to get additional information on ICD-10-PCS and the fact that it will not be used on the OASIS reporting.

Slide 13 gives you information on where you can find the annual updates to the ICD-10 coding system. CMS posted the 2012 version of ICD-10-PCS in June of this year. This was an earlier date than in the past, when we posted them in December. This year for the first time we moved ICD-10-PCS, the 2012 version, up to June to match the timeline used with ICD-9-CM. We are doing this to get users familiar with this schedule, because the same timelines will apply in code updates when we move to ICD-10. This year the ICD-10-CM updates, which Donna Pickett will discuss later, will be posted in December.

Slide 13 also gives you a link for the ICD-9 Coordination and Maintenance Committee. This is the committee that discusses the maintenance and updating of both ICD-9-CM and ICD-10. If you are curious about what new codes are being discussed, you can go to this website.

On slide 14, we point out that we are now in a partial freeze mode. The last regular annual updates to both ICD-9-CM and ICD-10 were done on October 1, 2011. Obviously, the ICD-10-CM codes will not be posted on our website until late this year, but that will be the last major update to ICD-9 and ICD-10.

On October 1, 2012 and 2013, we will have only a limited number of code updates to both ICD-9-CM and ICD-10. These limited code updates will only be used to capture new technology and new diseases.

As you can see on slide 15, there will be no update to ICD-9-CM on October 1, 2013, because this system will no longer be a standard under the Health

Insurance Affordability and Accountability Act (HIPAA) for services provided on or after October 1, 2013. On October 1, 2014, we will begin regular updates to ICD-10.

Slides 16 through 19 list a variety of websites where you can get additional information about ICD-10 and MS-DRG conversion 5010, and other resources that you might find useful.

With this, I'll turn the call over to Leah.

General Implementation Planning and Strategies

Leah Nguyen: Thank you, Pat. Next we have a joint presentation on general implementation planning and strategies. We are pleased to have with us today Sue Bowman, Director of Coding Policy and Compliance with the American Health Information Management Association, and Nelly Leon-Chisen, Director Coding and Classification at the American Hospital Association.

Nelly Leon-Chisen: Thank you. We're now on slide 20. Sue and I will tag-team this segment of the program. Both AHA and AHIMA have thought long and hard about general implementation planning and strategies, so we agreed to present this section together.

Before we talk about the work needed to implement ICD-10, let's refresh our memory about what the benefits of ICD-10 are. Why do we have to change? We know that change is hard, especially when it requires work and other resources.

Slides 21 through 24 cover the benefits of ICD-10 and the areas where the additional specificity of the codes can have a significant impact. In the interest of time, please read the slides on your own. Essentially we wanted this to be a reminder: We can anticipate benefits from better data that can result in better information to be used for more accurate decisions.

ICD-9-CM is outdated, and a more contemporary and detailed coding system will support improved information in different areas, such as quality

measurement, public health, research, organizational monitoring and performance, health information technology, and reimbursement. Ultimately, let us not forget that better information can support better patient care.

On slide 25, we have an example of the detail available in ICD-10-CM compared to ICD-9. This relates to a National Quality Forum indicator on seriously reportable events, where the indicator is looking at problems associated with the malfunction of a device. With ICD-9, we don't know if the problem is with a device, a graft, or an implant. ICD-10 does provide that information and much more. You can also track the problem from an initial encounter to a subsequent encounter or sequela.

Slide 26 presents information on the external causes of morbidity codes. Unfortunately, recent articles have in a very humorous way focused on this section of codes, which may have led some to believe that ICD-10 is all about detail and information that nobody cares about. Granted there are codes that are not commonly used, but a provider would only use codes that represent diseases or conditions or situations that a practice or a hospital encounters. So that wouldn't be every code in the book, just as you probably don't use all the codes in the ICD-9 book today.

External cause codes serve an important purpose, and they are not limited to ICD-10. They allow the classification of environmental events and circumstances when they are the cause of injuries and other adverse effects. These codes provide a better understanding of these problems and can be used to guide injury prevention programs and important public health decisions. They also help us to better understand the health care costs associated with these events.

As with ICD-9-CM, there is no national requirement for mandatory external cause code reporting, although they are required from hospitals by many State-based data reporting systems.

How useful codes can be in conveying information can be seen from the examples on slide 27 about injuries from boating accidents, car accidents, and falls from motorized mobility scooters.

We acknowledge that transitioning to ICD-10 is not an easy task. There is work involved, and many providers are feeling stretched. Possibly adding to the challenge are the number of overlapping timelines, shown on slides 28 through 30, such as those involving Meaningful Use and Health Reform Initiatives, in addition to ICD-10. However, ICD-10 is not a separate, competing initiative, but the foundation for the initiatives listed on these slides. ICD-10 will help us gather information that can help providers do a better job of understanding and serving patients. It will enable us to better analyze this information to meet requirements related to bundled payments, hospital-acquired conditions, value-based purchasing, and preventing readmissions.

Unfortunately, we don't have enough time on today's presentation to share with you more specific clinical examples of the better information ICD-10 can provide. What I can tell you is that there are very significant consequences of poor preparation for the transition. As providers, we depend on smooth processing of claims for cash flow, so it's important that we devote our full attention to preparation. Slide 31 outlines a number of these potential consequences, including denials, processing delays, backlogs, and so on. The good news is that these problems can be mitigated with proper advance preparation.

Now I'll turn you over to Sue, who will walk us through the impact of the change.

Impact of Change

Sue Bowman: Thank you. As Nelly mentioned, we're going to move on to talking about the impact of the coding system change. As I'm sure many of you are aware by now, those who have started your implementation preparation planning, the transition to ICD-10 presents many opportunities as well as challenges.

At this point, you might be more familiar with the challenges than you are with the opportunities. From Nelly's presentation, however, I'm sure you

recognize that with better detail and more data, there are a lot of exciting opportunities for acquiring more information and learning more about medical care in the future than we do today with ICD-9.

The scope and complexity of this transition are very significant, and coded data are more widely used now than when the United States transitioned to ICD-9 more than 30 years ago. Given all the places where ICD-9 codes appear or are used in some way in your organizations, the transition to ICD-10 requires extensive changes that will affect many systems, processes, and people.

It's not just a coding change affecting only the coder. It really is a transformational change throughout the organization, affecting all departments. I heard staff from one organization say in a presentation that when they were looking at all the systems and processes that were impacted by ICD-10, just about the only ones they had run across that would not be impacted in some way were the housekeeping service and the cafeteria. Everywhere else, they found that the ICD codes had an impact somehow.

Now we're on slide 34. I hope many of you have already begun your implementation planning and preparation process. If you haven't, it's very important to begin as soon as possible. It does take some time, and as we're going to talk about with the initial steps of the impact assessment, you really need to dig into it to know how much work is ahead of you.

A smooth, successful transition by the compliance date of October 1, 2013 requires a very well-planned and well-managed implementation process. An organization that has started the planning process early, prepared thoroughly, provided education to the right people at the right time, and conducted appropriate testing before implementation can expect to have a smoother transition and an earlier realization of the benefits from moving to ICD-10.

Slide 35 shows you where we are right now on the 5010 timeline. External testing is supposed to be completed by the end of this year, and the compliance date for using version 5010 is January 1, 2012.

Implementation Strategy

Now we're going to move on to discuss implementation strategies. The phases and implementation steps we're going to cover today are based on AHIMA's ICD-10 Planning and Preparation Checklist, which is available on our ICD-10 Web site. It was developed to guide health care organizations in effectively planning and managing the ICD-10 transition. This resource has been developed to assist all types of organizations in the implementation of ICD-10. While this checklist might look on the surface as though it's designed for larger organizations, it can easily be scaled down for smaller organizations, including physician practices.

Slide 38 gives you the link to this checklist and a brief description of the different phases. It's helpful to break the implementation planning and preparation process down into chunks or phases so it doesn't seem as overwhelming, and so you can have goals to complete at different steps along the way, and success stories by which you can celebrate your progress.

The timeline on slide 39 gives suggested dates for the different phases: implementation plan development and impact assessment, implementation preparation, go-live preparation, and post-implementation follow up. The quarters here refer to calendar year quarters, not Medicare fiscal year quarters. These dates are only a general guideline, and the timeline is likely to vary due to a number of factors, including the type, size, and complexity of the organization. Also, the phases are not mutually exclusive; they will probably overlap.

Today we're mainly going to talk about Phases 1 and 2. Phase 1, implementation plan impact assessment, ideally should be finished by now. If you haven't gotten it started, it's critically important to do so right away, because the clock is definitely ticking.

Completing Phase 1 early on is critically important because without the impact assessment, you can't reasonably predict the length of time or the amount of resources that are going to be required for the implementation preparation and go-live phases. Therefore, without completing this first phase

you can't plan an accurate timeline or budget for the work involved. Delayed completion of this phase will jeopardize the organization's ability to complete all the tasks by the compliance date, which can risk claims rejections and payment denials.

Phase 1—1st QTR 2009-2nd QTR 2011

Slide 41 lists the steps involved in Phase 1. The biggest piece of this phase is an assessment of the organization's readiness for the transition. This includes such tasks as:

- Identifying all affected business areas and individuals, including medical and clinical staff as well as administrative staff
- Identifying all affected systems, applications, and databases
- Considering current and future organizational plans and acquisitions—such as mergers, purchases of physician practices or other facilities—that impact your implementation planning, and
- Determining the likely impact on all the operational processes you currently use ICD-9 codes for, and analyzing these processes.

You will need to find all the places where ICD-9 codes are being used in some capacity today and where the ICD-10 codes might be used in the future, including processes that might use ICD-10 codes in the future but do not currently require ICD-9 codes. Although certainly not an easy task, this is a major component of Phase 1 of the implementation preparation planning.

The impact on documentation processes and workflow will need to be assessed. You should also evaluate the data flow and operational processes that will be impacted by the ICD-10 transition, and determine where you might make improvements in those processes. You don't necessarily want to take all your current processes and convert them to ICD-10. The ICD-10 conversion presents a great opportunity to examine how your current processes could be improved and made more efficient and productive.

Slide 42 describes the facility-wide systems audit, which involves taking inventory of all system applications and databases that use ICD-9-CM codes.

This isn't just for hospitals; it's for any health care entity that has IT systems which would be affected by ICD-10. This can be a big job if you have a lot of systems, as many organizations do.

Some considerations in relation to this audit are:

- How many systems will be affected and what types of system changes will be made
- Whether the system was developed and maintained in-house or by an outside vendor
- Whether an application service provider is used for any of the applications
- How ICD-9 codes are used in each system
- Where the ICD-9 codes originate from, and
- How the quality of the data in the system is being checked.

This is an opportunity to critically examine all the processes and reports currently in use, assess their necessity or value, and identify areas where improvements can be made. Needs for new or upgraded hardware and software requirements should be identified. For example, you may decide to purchase computer-assisted coding technology to facilitate both the transition process as well as the ICD-10 coding process after implementation.

Slides 43 and 44 list some of the systems and applications that could be affected by the transition to ICD-10. This certainly is not an all-inclusive list, but it gives you an idea of the scope of the transition's impact and the types of systems that could be impacted.

On slide 45: A gap analysis of the coding and documentation practices in your organization should be conducted. This means measuring the coder's baseline knowledge of anatomy, physiology, pharmacology, and medical terminology so that education can be targeted at the areas of identified weaknesses and gaps.

Measuring the coder's baseline knowledge now will shorten the ultimate learning curve, improve coding accuracy and productivity, and accelerate the ultimate realization of the benefits of moving to ICD-10. Refreshing the coder's knowledge of the biomedical sciences based on the gap analysis is the

type of training that can be done now, but it's not the same as the intensive coder training that should be provided closer to implementation.

On slide 46: The quality of medical record documentation needs to be assessed. This can involve evaluating samples of various types of medical records, or the diagnoses, procedures, or areas known to be frequently problematic from a documentation standpoint in ICD-9.

This assessment is conducted to determine whether the documentation supports the level of detail found in ICD-10. Then documentation improvement strategies can be implemented to address areas where documentation is found to be lacking. Changes in documentation capture processes might be considered, such as prompts from electronic health record systems to help facilitate improvements in documentation practices. It helps in this step to have a physician champion who can assist in medical staff education and help promote the positive aspects of moving to ICD-10, so that the transition is a positive experience for all.

Keep in mind that nonspecific codes are still available when necessary. The goal here is not to eliminate the use of all unspecified codes. There are times when even the clinician doesn't have the information about the disease process necessary for assigning a more specific code.

The goal, however, is to work toward better documentation in order to: avoid misinterpretation by third parties, justify the medical necessity of the services, provide a more accurate clinical picture of the quality of care provided, and support current and future initiatives aimed at improving quality and reducing cost. Any issues related to inconsistent, missing, conflicting, or unclear documentation will still have to be resolved by the provider, just as they are today.

The next step involves developing a training plan. First, identify the specific groups who need training based on their roles and responsibilities. Keep in mind that multiple categories of users of coded data require varying types and levels of ICD-10 education, and the education will need to be provided at

different times. This goes well beyond coders; everyone using ICD data will need some type or level of training.

Second, determine the method and timeline for training and the most cost-effective method of providing that training. Will it be provided through internal or external mechanisms, or both? Will it be online training or face-to-face? When will various categories of data users need the training? Don't forget any contract coding services, and be sure to contact them regarding their training plans and timelines.

It's still too early to provide intensive coder training—meaning training for individuals who won't be assigning ICD-10 codes to medical records until October 2013—unless there is an identified need to train individuals earlier because they're involved in an implementation preparation activity that requires comprehensive coding knowledge now. People who won't be assigning ICD-10 codes until October 2013 will still be coding their medical records in ICD-9 and following that process. Training them too early would mean they might forget what they've learned and require some retraining in 2013, which could add additional cost to the process.

When it's time, providing intensive training is expected to take two full days of ICD-10-CM training for those who just need that system and not ICD-10-PCS. Because ICD-10-PCS is completely different from ICD-9-CM, it will require a little more training than ICD-10-CM. For budgetary reasons, we estimate around 50 hours could be needed for both ICD-10-CM and ICD-10-PCS training.

We've heard from some organizations that coders sometimes want additional practice hours. In addition to training on coding system rules and conventions and code application, coders may want more practice time, not face-to-face instruction only. This is good to consider as part of the budgetary process as well in determining the number of training hours.

Slide 49 provides examples of some of the categories of individuals within your organization who may need some level of ICD-10 education—not necessarily intensive coder education, but some level of education—about the

ICD-10 code set in order to understand the data they are using or reporting. This slide gives you some idea of the categories of personnel you might not have thought about who have some impact or touch coded data in some way in their jobs.

Part of Phase 1 is also developing an ICD-10 budget (slide 50). This involves identifying all the ICD-10 transition expenses and whether there are any associated costs, such as software modifications, education, hardware and software upgrades, staff time, and temporary or contract staffing to assist with increased work resulting from the transition, such as coding and billing backlogs, and so on.

The amount of anticipated cost for the ICD-10 transition depends on a number of factors, including the size and complexity of the organization; the number of systems; any need for outside technical assistance; the number of applications and interfaces to be updated; and how many people need to be trained and their current coding background, which affects how much training they will need.

We are often asked to give a magic cost number for a particular organization. I wish I could say there was such a thing, but cost depends so much on the particular health care entity and its structure and processes. It depends on whether the organization is part of a hospital system; whether its computer system is part of a hospital's system or has its own; what its vendor contract agreements are; who is going to incur the cost of the upgrade; and how many staff need to be trained and what they need to be trained on. There are many different factors.

The largest budgetary expenses, however, are generally for the systems upgrades and the educational piece. Other possible transition expenses include consulting services, report redesign or development of new reports, reprinting paper forms, data conversion, and additional software or other tools and resources to facilitate the ICD-10 transition or improve operational processes, such as moving to computer-assisted coding technology, which I mentioned earlier.

As part of this process, you will need to identify whose budget is going to be responsible for each of these costs, including the systems changes, such as hardware, software upgrades, and education.

Also, you need to determine which costs you are going to consider ICD-10 costs. I've heard some people talk about including the entire cost of their EHR system as part of the ICD-10 costs. This is a little different and not directly related to ICD-10 costs. You really need to look at what you are bundling into what's considered an ICD-10 cost for budgetary purposes.

On slide 51: If you haven't already done so, you need to start asking your business associates, such as systems vendors, payers, and other providers, about their readiness and timelines for upgrading software and other processes that you interact with them on. Make sure you ask specific questions about their timeline and when they'll be ready to test.

It's not enough to be told by a vendor, "Don't worry, we'll be ready." You will need to ask for more details. Follow up with them to see where they are on their own timeline, and whether they have met goals when they told you they would. For example, some of the questions to ask the vendors include:

- What systems upgrades or replacements are needed to accommodate ICD-10?
- What costs are involved, and will the upgrades be covered by existing contracts? If not, what would be the projected cost, and when will the cost be incurred?
- When will upgrades or replacement systems be available for testing and implementation?
- What customer support and training will be provided?
- How will their products and services accommodate both ICD-9 and ICD-10 as you work with claims for dates of service, both before and after October 1, 2013?
- How long will they be able to accommodate both code sets for longitudinal data analysis going into the future?

AHIMA has a sample ICD-10 vendor readiness questionnaire and customizable letter that you could send to vendors, which is available on the ICD-10 page of our Web site.

Now I will turn the call back to Nelly.

Phase 2—1st QTR 2011-2nd QTR 2013

Nelly Leon-Chisen: Sue talked to us about the different activities in Phase 1. Now we look at Phase 2, carrying us into the second quarter of 2013 (slide 54).

Training on the use of the general equivalence maps, or GEMs, as well as mappings, will be needed. This training will not be needed for everyone, and certainly not for those who will be doing the day-to-day coding. It will be needed for a few key people who will work on mappings, and it should be provided to personnel involved in data conversion projects. CMS presented an excellent program on GEMs in May 2009; you can read the transcript of this program or download the podcast of it.

You will need to determine the impact on longitudinal data analysis. Don't assume all your legacy or historical data will need to be converted to ICD-10. If you don't plan to use the data, or if you hardly ever use it, there is no automatic need to convert all of it.

If you do make a decision to convert, think about how it will be converted. In some instances you'll decide to link data using mapping applications. If coded data will be mapped between ICD-9-CM and ICD-10-CM/PCS using GEMs, will you need to develop application-specific mapping? In other instances you may decide to maintain data separately according to the source code sets. In other words, you may keep your historical data in ICD-9 and code in the future with ICD-10. Then only when you need to, you could run a report in ICD-9-CM, and another report in ICD-10, and evaluate the two reports, or aggregate the results of those reports.

Moving on to slide 55: We continue to assess the quality of medical record documentation, implement documentation improvement strategies as needed,

and monitor the impact of documentation improvement strategies. Of course, if you are an HIM or coding professional, this is a never-ending task. It is not only related to ICD-10, but is something we have been doing with other changes, such as implementing present-on-admission, or POA reporting or hospital-acquired condition reporting, or addressing RAC issues.

Coders should continue to gain familiarity with ICD-10 code sets and coding guidelines. We are not yet at a point where intensive coding education will be required for coding professionals. At this point, we will work on improving our skills in areas that were previously identified in the gap analysis Sue mentioned earlier. For example, for hospital inpatient coding professionals, you may be looking at expanding coders' knowledge of surgical approaches and root operations in order to enable an easier transition to ICD-10-PCS.

Phase 2 is also the time to complete tasks identified during the impact assessment, which was covered earlier. You can see a list of those tasks on slide 56. They range from implementing systems changes, to addressing your policies and procedures, as well as user education and monitoring documentation improvement strategies.

For example, data users would be educated on the differences in the classification of diseases and procedures, including the definitions and code category compositions, in order to enable them to assess the impact on data trends. Data users would include staff involved in case management, utilization management, quality management, and data analysis.

Now is also an opportunity to re-engineer processes and workflows. This is where we get to make changes based on a better understanding of internal processes that were evaluated in Phase 1. There is also testing to be considered. During this time you will need to complete internal testing, and then you can begin external testing with business associates when they are ready.

On slides 57 and 58 we have additional implementation preparation steps. The project plan initially developed in Phase 1 will need to be refined, and the timeline and budget adjusted as needed.

As a provider, you will want to assess the potential reimbursement impact on your hospital or your practice. For example, as a hospital provider, you could take a look at the draft MS-DRGs Pat mentioned earlier, which CMS has posted, and perhaps use them to model the reimbursement impact. You could evaluate potential DRG shifts and changes in case mix index, and communicate with payers about anticipated changes in their reimbursement schedules or payment policies. If you have contractual agreements with commercial health plans, it's a good idea to take a look at how those would be affected as well.

If you are a physician practice, now may be a good opportunity to review fee schedules and see if there are any changes to the most common conditions your practice cares for. You will want to develop strategies to minimize problems and maximize opportunities. This includes assessing the potential impact of what happens when your coding productivity decreases and how you would address that. Will you plan for contract coders? Overtime? How will you assess your coding accuracy? What will be the impact if coding accuracy decreased? Will you assess that accuracy before claims are submitted, or will you do a random sample? Will you start your coders earlier than required so they can get enough practice and you can assess their accuracy before the go-live day?

Plan to eliminate any coding backlogs prior to the implementation, and don't forget to provide coding staff with adequate ICD-10 education, including refresher training immediately before the compliance date in order to reduce anxiety, improve confidence, and minimize a decline in productivity.

Slide 58: Follow up on the readiness status of business associates. Don't assume that if you contacted them early in 2011 they will be ready when they promised, as we've heard before. Check again to make sure they are still on track, and that the information you initially received is still valid. Better yet, if your agreements are up for renewal, you may want to consider negotiating a commitment that your business associates will support you and be ready by a certain date.

Plan ahead and develop a contingency plan. This way, if problems occur you have already thought through your options and are ready to react if needed. And, no, freaking out or retiring is simply not a contingency plan. Your contingency plan may involve setting aside financial reserves, considering backup systems, or budgeting for contract coders.

Also, develop a communication plan. This plan will outline the steps for how to report an issue that occurs at go-live: who the points of contact will be, how to disseminate information or updates to all parties, and any other items that may need to be resolved. Don't forget to provide senior executives and stakeholders with updates and get updates from your business partners.

Mapping

Let's talk about mapping, because we mentioned the GEMs. I'd like to take a couple of minutes to dispel some myths. Let's turn to slide 60. It is not necessary to learn or understand the GEMs in order to code with ICD-10. GEMs are reference mappings to help navigate the complexity of translating the meaning from one code set to the other code set. Be warned: if you don't understand coding to start with, the GEMs won't be of any help.

The GEMs are not meant to be a straightforward crosswalk, so don't look to them as the solution for all data conversion projects. One of the purposes of having maps between the old and new code sets is to analyze trend data, both pre- and post-implementation of ICD-10. Examples of the types of databases that may be converted are listed on the next slide.

As shown on slide 62, the GEMs should not be used when you have access to the medical record, or when you have access to actual descriptions or clinical terms describing the diagnosis or procedure. In these cases it would be much faster and more accurate to look up the codes, because the GEMs will give you all possible mappings, and some of these might not actually fit the clinical information you have available. If you have a small number of codes to be converted, it will be quicker to code than to use the GEMs. More importantly, the GEMs should not be used for coding medical records.

Other Implementation Considerations

Let's look at other implementation considerations (slide 64). Hopefully we can put to rest some doubts related to Coding Clinic and ICD-10. Many of you have relied on Coding Clinic as an important resource for the last 27 years, and are a little anxious about it going away because it has given you so much material over the years.

We want to let you know that we do plan to have a Coding Clinic available for ICD-10. It will continue to serve the same major functions the ICD-9 Coding Clinic does today. It will provide practical information with official coding advice, because you can rely on the fact that every question and answer published will have been discussed and approved by the Cooperating Parties and the Editorial Advisory Board, which also has representation from physicians.

Coding Clinic for ICD-10 will be offered in the same format the current Coding Clinic is available in. We have no plans to translate all previous issues of Coding Clinic into ICD-10, since many of those came up because of the need for clarification, where the ICD-9 codes were vague, or where there was no code that fit the description.

On slide 65, we note that in addition to Coding Clinic, the AHA also supports the Central Office on ICD-9, which serves as the coding clearinghouse for ICD-9 questions. We receive questions from all types of users and provide direct responses free of charge. Most of these questions are then published in Coding Clinic. The questions can range from simple questions about interpretation of coding guidelines, to more complex questions for new conditions or new technology where the classifications doesn't provide guidance. We plan to continue to provide this service with ICD-10-CM and ICD-10-PCS.

The field has been supported by AHA Coding Handbooks for ICD-9, such as the Faye Brown Coding Handbook. As part of our transition, we released over

the summer a similar coding handbook for ICD-10-CM and ICD-10-PCS in order to assist academic programs and others in their training.

On slide 66 we have a number of resources currently available from the AHA, and I'd like to highlight for you the Executive Briefing on Implementation. This is a free resource, available on our Web site, which covers several important areas related to implementation strategies. For 2012 we plan to have more audio seminars on ICD-10, as well as articles in our publications like *Hospitals and Health Networks*, and monthly blogs from CIOs discussing different aspects of implementing ICD-10.

Lastly—nothing like saving the good news for the end of my portion—I'm excited to announce that you can start sending your ICD-10-CM/PCS questions to the AHA Central Office or to Sue Bowman at AHIMA.

However, just as with ICD-9-CM, you must have a working knowledge of ICD-10 coding when you submit a question. In other words, we are not able to convert all your codes or all your encounter forms, or provide you with codes if you do not have a Code Book or don't have a clue how to code. The service is for coding advice, not for implementation issues. We have committed to reviewing ICD-10-CM/PCS coding questions with the Coding Clinic Board starting next year, with publication planned for the fourth quarter 2012 issue of Coding Clinic. Because of the partial code set freeze mentioned earlier by Pat, there will be very limited information in that issue, which normally includes the ICD-9 changes for the year. So this is an excellent opportunity to provide educational information on ICD-10.

On the last slide you can find links to the AHA, where these different references will be available.

National Committee on Vital and Health Statistics (NCVHS) Meeting on Provider and Vendor Readiness

Leah Nguyen: We are also pleased to have with us today Donna Pickett, Medical Systems Administrator, Classifications and Public Health Data Standards, at the

Centers for Disease Control and Prevention, with an update on the National Committee on Vital and Health Statistics (NCVHS) meetings on provider and vendor readiness.

Donna Pickett: Thank you. For those of you who are not familiar with the National Committee on Vital and Health Statistics, the NCVHS serves as an advisory body to the Department of Health and Human Services. It has a long history, roughly 60 years.

In 1996 the National Committee was restructured to meet expanded responsibilities under HIPAA. As part of those responsibilities, the National Committee has held hearings since 1996 on various aspects related to HIPAA standards, code sets, and transactions, including claims attachments, standards and operating rules, and other related issues. On June 17 this year, the National Committee held its second public hearing to review industry progress toward adoption of the updated version of the standards and code sets, namely, 5010 and ICD-10 code sets.

This hearing was attended by approximately 26 individuals representing a number of entities within the stakeholder industry: Federal agencies such as CMS and the Indian Health Service, health plans such as Blue Cross Blue Shield Association (the national association), AHIP, providers such as the American Medical Association and the American Hospital Association, as well as representatives from clearinghouses, vendors, other government entities, and State Medicaid agencies.

A number of cross-cutting observations and recommendations came out of the day-long discussions at this hearing. Slide 72 presents a high-level overview of some of these observations and recommendations.

Overall, testifiers expressed concern about both 5010 and ICD-10 industry readiness. One recommendation made was that Health and Human Services should use all communication vehicles to reiterate and emphasize that the compliance dates are not changing, which you also heard earlier today from Pat Brooks and Elizabeth Reed.

It was also recommended that HHS should immediately make wide-scale announcements to industry stakeholders, association contacts, and others to more strongly encourage and foster testing between trading partners. This recommendation relates specifically to 5010, as its implementation date is January 2012.

On slide 73, I've listed a few ICD-10-specific observations from this hearing. The first, related to crosswalks and the general equivalence maps, is that there's an ongoing need, which will escalate, to educate people on the GEMs and crosswalking. You've just heard Nelly talk about those initiatives and the fact that excellent information has been provided at the ICD-9-CM Coordination and Maintenance Committee about the GEMs, and that information is still available on the CMS Web site.

Second, many testifiers indicated they would not be using GEMs or crosswalks, as they originally planned to do their conversion, but will natively start using the ICD-10 codes themselves, and not take the ICD-10 codes and translate them back to ICD-9-CM codes.

Another important issue that arose was that some testifiers expressed concern about the "explosion of proprietary and vendor provided crosswalks and GEMs," and its implications. It was suggested that additional discussion was needed to help the industry evaluate vendors and the quality of the products they are going to make available.

Slide 74 presents two additional key recommendations related to the GEMs and crosswalks. One is that HHS should work with associations to highlight the educational and resource information that is already available. We have already heard Nelly and Sue, representing AHA and AHIMA, describe the resources available from their organizations and on their Web sites. There is also a vast amount of information available on the CMS Web site.

Secondly, associations should solicit feedback from their constituents about the content and quality of available resources, so that modifications can be made to them during the 2011 and 2012 calendar years.

The NCVHS meeting also resulted in some observations and recommendations specific to ICD-10 (slide 75). Under “Resources,” one of the observations was that there are uncertainties about the availability of an appropriate number of coders in the industry and their geographic location, making availability of trainers and coders a concern for some testifiers.

From this concern followed a recommendation that HHS collaborate with organizations such as AHIMA to assess the current levels of coders in the industry and the number of coders needed by 2013, identify potential gaps, and invest in expanding educational opportunities and resources to increase workforce capacity.

As shown on slide 76, it was also recommended that, per ACA provision, the National Committee hold additional hearings, either in late 2011 or early 2012, on potential areas where standardization will benefit the industry as a whole. These areas include adoption of HIPAA standards by entities who are not covered under HIPAA, such as workers compensation, auto insurance, and property and casualty. It is recommended that HHS encourage stakeholders in these entities to implement the transaction standards and code sets adopted under HIPAA not only to improve standardization, but also to bring the benefits that accrue under HIPAA to other users of the data, including those who are using coded data for their programs, such as workers compensation.

Slide 77 mentions how entities not covered under HIPAA are impacted by the transition to the new code set. Public health is not a covered entity. However, public health entities such as the CDC receive coded data (currently in ICD-9-CM) from providers, or use ICD-9-CM in their surveillance programs to code information captured from State and local governments and elsewhere. Thus, public health professionals also are concerned about the transition to the ICD-10 code sets.

CDC recognized these issues early on, so we formed a workgroup earlier this year to address them. Currently the workgroup includes approximately 21 members from across the agency. Approximately 90 programs within CDC will be affected by the transition to the new code sets, because they either

code using ICD-9-CM or take in coded data from CDC partners and other programs.

Slide 79 lists the programs we've identified thus far. We will continue to do outreach to make sure we have identified any other programs that may be impacted by this transition. Part of the transition workgroup's goal is to disseminate information about the transition to ICD-10 code sets and to provide resources and tools to assist with that transition.

Within a month we will be conducting an agency-wide needs assessment survey to identify program needs, gaps, and other issues. This assessment will also draw from the experiences of programs within CDC that have already undertaken their implementation planning and have done their own needs assessment. We will look into partnering with agencies outside of CDC that have also begun these activities so we can gather lessons learned. The goal of this activity is to collect and share best practices and best solutions.

As you might understand, CDC and some other Federal agencies not directly involved in reimbursement issues have slightly different tools that don't necessarily touch on coverage determination or reimbursement issues. However, the codes are key to the functioning of many of the 90 programs I mentioned.

Slide 80 lists other steps the CDC has taken or will take related to the ICD-10 transition. We've already conducted webinars about preparation for the transition to the ICD-10 code sets. We are doing outreach to external partners, because they too will be affected, even though they are not HIPAA-covered entities but they too use code sets. We will also be doing outreach to vendors to see what aspects of their experience in preparing for hospital and health care transitions we can apply to the public health sector.

Slide 81 mentions three Web sites for those of you who are interested in additional information. The first one further describes the deliberations of the National Committee on Vital and Health Statistics, presenting all official NCVHS documents including meeting transcripts and presentations. This site

also includes PowerPoint presentations given by testifiers at the committee meeting.

The CDC Web site contains the ICD-10-CM files and related materials, including the diagnosis general equivalence maps. If you access the diagnosis GEMs on the CDC page, you will also see links to the CMS page for PCS and other related materials. In fact, as Pat mentioned, we link to each other's Web sites for transparency and ease of access to the files.

The ICD-9-CM Coordination and Maintenance Committee Web site is also listed here. Information on diagnosis codes and the codes being proposed for ICD-10-CM is available on this site, as well as the full proposals and summaries and audio of the meeting proceedings.

With that, I will turn the microphone back to Leah.

Medicare Fee-for-Service Claims Processing, Billing, and Reporting Guidelines for ICD-10

Leah Nguyen: Thank you, Donna. Our final presentation—on Medicare Fee-For-Service claims processing, billing, and reporting guidelines for ICD-10 will be given by Sarah Shirey-Losso, Hospital Team Lead, and Antoinette Johnson, Health Insurance Specialist, both from the Center for Medicare, Provider Billing Group.

Sarah Shirey-Losso: Thanks, Leah. Before I turn the call over to Antoinette Johnson to speak about specific Medicare Fee-For-Service claims, I want to give an update on some more general ICD-10 activities we've been working on under Medicare Fee-For-Service claims processing.

Beginning this past January, and continuing each quarter until implementation, we're accomplishing various systems activities in analysis, coding, design, and implementation. We've been diligently working on converting about 200 hard-coded Medicare Part A and Part B Fee-For-Service edits, working with our clinicians, using GEMs, and analyzing those edits to make sure they work the way they were intended to work when we were using

ICD-9. We're also converting various tables and continue to expand internal files and screens for our claims processors.

With that, I'll turn it over to Antoinette.

Antoinette Johnson: Thank you, Sarah. During this portion of the call I will be providing a brief overview of the claims processing, billing, and reporting guidelines for ICD-10. As you all are aware, on October 1, 2013, all Medicare claims submissions with diagnoses and hospital inpatient procedure coding will change from ICD-9 to ICD-10.

This means all entities covered by HIPAA must make the transition, including any systems changes, throughout the entire health care industry. As stated earlier, all entities covered under HIPAA are therefore required to use ICD-10 code sets and standard transactions adopted under HIPAA for dates of service on and after October 1, 2013.

Slide 84 highlights the key components of CMS change request CR 7492, transmittal 950, issued August 19, 2011, which provided guidance on reporting diagnosis codes, claims submissions, and date span requirements for ICD-10 for Medicare Fee-For-Service claims. The change request outlines technical business requirements for our Medicare contractors as to how to code their systems in preparation for the implementation of ICD-10. For your convenience, on this slide we have provided a link to MLN Matters article 7492 for more detailed information.

Slide 85 outlines general reporting of ICD-10 codes. Providers and suppliers are still required to report all characters of a valid ICD-10 code on a claim. ICD-10 diagnoses codes have different rules regarding specificity, and providers and suppliers are required to submit the most specific diagnosis codes based on the information available at the time. In addition, regarding procedure coding, ICD-10-PCS codes will only be used by inpatient hospital claims, as is currently the case with ICD-9 procedure codes.

Slide 86 provides details of submitting diagnosis codes on claims upon implementation of ICD-10. Some of the key points are:

- ICD-9 codes are no longer accepted on claims with dates of service October 1, 2013 and later.
- ICD-10 codes will not be recognized or accepted on claims before October 1, 2013.
- Claims cannot contain both ICD-9 codes and ICD-10 codes.
- If claims containing diagnosis codes are submitted incorrectly, institutional claims will be returned to the provider, and professional and supplier claims will be returned as unprocessable. Providers at that time may correct their claims with the appropriate ICD-9 or ICD-10 diagnosis code and resubmit.

Lastly, slide 87 provides guidance on claims for services that span the implementation date of October 1, 2013. In some cases, depending on the policies associated with those services, there cannot be a break in service with time—for instance, anesthesia services—although the new ICD-10 code set must be used effective October 1, 2013.

In our published guidance, we have direction on how to submit claims for inpatients as well as outpatients. For outpatient claims, we asked that you split the claim and use the “from” date. For inpatient claims, we asked that providers use the “through” date or the discharge date if services span the October 1 implementation date. Again, the provider article includes a detailed table that gives claims submission requirements by facility type, provider, and supplier, including special claims processing circumstances.

This concludes my portion of the presentation on Change Request 7492. Back to you, Leah.

Question and Answer Session

Leah Nguyen: Thank you, Antoinette. You’ve heard a lot of information that we hope you all find helpful in implementing ICD-10. With the remaining minutes of this call, we will take a few questions.

Operator: We will now open the lines for our question and answer session. To ask a question, press star followed by the number 1 on your touchtone phone. To

remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking your question to ensure clarity. Please note that your line will remain open during the time you are asking, so anything you say or any background noise will be heard in the conference. Your first question comes from the line of Edward Mulgrew.

Edward Mulgrew: When we submit claims on October 1, are we talking about the date of service as being the effective date for the ICD-9 or ICD-10?

Antoinette Johnson: Yes. All claims that you're submitting for ICD-10 will begin with a date of service of October 1, 2013. So it's the service date.

Edward Mulgrew: Thank you.

Operator: Go ahead, participant, your line is open.

Kim West: Hello, my name is Kim West. I'm with McKesson Corporation. I was wondering if there's any significance to the rumors about pushing back the date of October 1, 2013.

Denise Buenning: This is Denise Buenning. I'm Director of the Administrative Simplification Group here at CMS, and I'm responsible for the industry implementation of ICD-10. I can tell you that there is no truth to the rumor. There is no push-back. The date for ICD-10 remains October 1, 2013.

Kim West: OK, thank you.

Operator: Your next question comes from the line of Sue Welsh.

Sue Welsh: In looking at the ICD-10 conversion, is anyone working on converting the diagnoses in the NCDs to the ICD-10 format, so that we have some consistency in the administration of those?

Pat Brooks: Yes, Sue. I gave web links. We had previous discussions on the last conversion call, and during that call people from our coverage office talked about a process they were undertaking to do National Coverage Decisions.

Perhaps in a future call we can ask them to give an update on where they are. They have not posted anything yet, but they did give a previous call where they said they were working on NCDs.

Sue Welsh: Thank you very much.

Operator: Your next question comes from the line of Lynne Shaffer.

Lynne Shaffer: Hi. The other caller asked about the date of service. What if it's an inpatient who comes in, let's say, on 10/1 and leaves on 10/16?

Pat Brooks: If you'll look at slide 7, you'll see that we use the date of discharge for hospital claims. So if the person comes in before October 1, but is discharged after October 1, the date of discharge determines the use of ICD-10. That example is on slide 7.

Lynne Shaffer: What about an observation patient?

Antoinette Johnson: If it's an outpatient service, which is observation—again, if you look back at slide 87, we asked that the providers split the claim and use the “from” date in that instance.

Operator: Your next question comes from the line of Trish Twombly.

Trish Twombly: I had two questions actually. I just attended one of the AHIMA Train the Trainer conferences, and they said that home health guidelines had not been released yet for ICD-10. My question is, Do you have any idea when home health-specific guidelines will be released? My other quick question is, Can you direct me to where I can find the grouper logic for ICD-10? Specifically, I'm looking for what codes are going to be manifestation codes in the ICD-10 system.

Pat Brooks: Please look at slide 11. We had a home health person talk briefly about what they had done so far, and we gave a link for you to listen to that call.

Trish Twombly: I had to dial in late, so I thank you for that. How about the grouper logic?

- Pat Brooks: The first link on slide 10, the MS-DRG conversion project, takes you to the complete Definitions Manual for the current version we've worked on. We also provide links where you can purchase software for the ICD-10 MS-DRG grouper to test. That link will give you all this detailed information.
- Trish Twombly: Alright, but that's for inpatient settings, right? DRGs?
- Pat Brooks: That's correct, that's inpatient MS-DRG.
- Trish Twombly: Alright, so there isn't anything yet for the HHRGs in the home health setting?
- Pat Brooks: No, there is not anything released yet for the others. I think MS-DRG's was pretty much in advance of all the other payment systems, since the people who worked in that area also worked on the creation of ICD-10-PCS. We decided to do ours first so others within the agency could learn from us. The other payment systems are taking what we've done and applying it to their payment systems, and once they are ready, they'll be releasing theirs too. We were quite early with the ICD-10, MS-DRG.
- Trish Twombly: Thank you very much, Pat.
- Operator: Your next question comes from the line of Deborah Moore.
- Deborah Moore: Hello. My question is, What is your response to the AMA House of Delegates voting to stop implementation of ICD-10?
- Pat Brooks: I can tell you what our press office said. I'll just read you the comment: "Implementation of this new coding system will mean better information to improve the quality of health care and more accurate payments to providers. CMS is giving significant transition time and flexibility to providers to switch over, and we expect all providers to be in compliance at the end of this process."
- Deborah Moore: Thank you.
- Operator: Your next question comes from the line of Brenda Ding.

Brenda Ding: Hello. I was going to ask the same question about the AMA. Is that press release out on the site already?

Pat Brooks: That is not a press release, it is a statement, and I don't know that it has necessarily been posted to the website.

Brenda Ding: OK. The other question I had is in regard to testing. The 5010 testing that has been occurring it seems has been lagging. I'm really concerned about ICD-10 testing. How is end-to-end testing going to be achieved? When will CMS have some guidelines or guidance in regard to end-to-end testing and ensuring that we are able to test through the adjudication cycle?

Pat Brooks: We don't fully understand the question. Maybe if you could clarify. Are you talking about provider testing, or could you explain the question?

Brenda Ding: Yes, I am talking about provider testing, meaning that the providers would be able to submit test claims. I'm not sure if CMS is going to create some dummy data that would be used and allow providers to test with certain accounts and insurance numbers, and thus be able to test different scenarios to ensure that things are working properly.

Sarah Shirey-Losso: This is Sarah in the Provider Billing Group. At this time we don't have any plans for provider testing. We plan to do our own internal system testing in the last 6 months, between April and October.

Brenda Ding: So when they just talked in the presentation about external testing—how will we really do external testing if CMS is not going to allow us as providers to be able to test?

Denise Buenning: I think how that would be achieved is still up for discussion. Obviously, it would take a lot to get to a testing mode, where we could actually pre-test, so to speak, before the actual implementation. That's still a topic under discussion at this point.

Brenda Ding: Thank you.

Leah Nguyen: We realize there were a lot of questions today, and I'm sorry that we are not able to take more of them at this time. Don't forget—you can still e-mail your questions to ICD10-National-Calls@cms.hhs.gov. This e-mail address is also listed on slide 91. If you have a question for a particular speaker, please be sure to include that person's name in the subject line.

Before we end the call, for the benefit of those who may have joined the call late, please note that continuing education credits may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS national provider calls. Please see slides 89 and 90 of the slide presentation for more details.

We would like to thank everyone for participating in the ICD-10 Implementation Strategies and Planning 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, Pat Brooks, Elizabeth Reed, Sue Bowman, Nelly Leon-Chisen, Donna Pickett, Sarah Shirey-Losso, and Antoinette Johnson for their participation. Have a great day, everyone.

END