Centers for Medicare & Medicaid Services
ICD-10-CM/PCS National Provider Call for Hospital Staff
Moderator: Ann Palmer
October 14, 2008
12:30 p.m. ET

Operator: Good morning, my name is Alicia and I will be your conference operator today. At this time I would like to welcome everyone to the ICD-10-CM/PCS National Provider Call for Hospital Staff.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during that time, simply press star then the number one on your telephone key pad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Palmer you may begin your conference.

Ann Palmer: Thank you. Welcome to the Centers for Medicare & Medicaid Services, ICD-10-CM/PCS National Provider Conference Call for Hospital Staff. Please note that this call is being recorded and will be transcribed. The call transcript will be posted shortly after this call.

You can find call transcripts and other conference call information by selecting CMS Sponsored Calls on the left side of the ICD-10 Web page located at www.cms.hhs.gov/ICD10.

Speakers from the four ICD-9-CM Cooperating Parties, which represent a long-standing public and private sector partnership between the Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, American Hospital Association and American Health Information Management Association, will be presenting today.

One practicing physician will also be part of our discussion. A PowerPoint has been developed and posted on the ICD-10-CM Sponsored Calls Web page for participants to follow along with the presentation. Our first speaker today is Dr. Lee Hilborne who is the President of the American Society for Clinical Pathology, Professor of Pathology and Laboratory Medicine at the University of California, Los Angeles, Health Services Researcher and Consultant to the Rand Corporation in Santa Monica, California, and the Medical Director of Quest Diagnostics in Southern California. Dr. Hilborne is going to discuss ICD-10 implementation issues. Go ahead Dr. Hilborne, please.

Lee Hilborne: Well, thank you. Good morning and good afternoon to those of you on the call depending on where you are. It's certainly a pleasure to talk to you since this group, our hospital colleagues, is really certainly an important constituency that needs to be involved in the transition to ICD-10.

And what I wanted to do was really give a little bit of a perspective from that of a physician, but a physician who has been involved in hospital as well as other issues.

As was mentioned, I'm Professor of Pathology and Laboratory Medicine at UCLA, but I've also worked very closely with and continue to work with our care coordination and our patient business services colleagues to address coding issues.

So from the standpoint of all of my roles collectively, I come to you with experience in hospital operations as well as clinical practice and research. I think that as we talk about the transition to ICD-10 - and I was for a number of years directly responsible for the coding department at UCLA - and now continue to work with them.

I've been listening to this discussion now for well over a decade and have had a chance to look at ICD-10 and think about the transition, et cetera, et cetera, and am impressed really that it's taken so long to get to this point.

But I think that it's time to really congratulate those who are on the call for taking the initiative to listen to this and to the government for taking the initiative to finally push us to make the transition that is inevitable and that we need to take.

As I look at it from all of my hats that really, that the movement to ICD-10, to a new coding system that has more detail is really essential. If you look at what's been important for where coding has been, it's critical now to the interface of hospital as well as other clinical practices.

The data started out originally being used, of course, for public health and public health tracking, which it continues to do but has now morphed into being used for reimbursement, which we're all familiar with as well as quality initiatives.

And, in fact, now even the pay for performance initiative is being tied into coding. The problem is that the data that we have is really not robust enough to be able to make the kinds of assessments we need.

So that from the standpoint of understanding quality, of areas where hospitals are excelling and areas where there are opportunities for improvement, we need to have something that's a little bit better, and I think ICD-10 really offers that.

The other issue from the standpoint of reimbursement, certainly that we've migrated to MS-DRGs, but really that a more robust system will help us collectively get better payment for the kinds of resources we use because we'll be able to have better data on which to drive those kinds of decisions.

So I think it does provide an opportunity for us to better provide information relative to the kinds of care - the care that we provide. But I do think that this - we should see this as a major opportunity for us to really move forward.

Now I don't want to minimize this, obviously, but this is going to be a huge effort, but if it is - and given it's such a huge effort - it's really something that we all need to come together on and work on collectively.

And certainly for those folks that are on the phone, particularly people who are involved in health information management, particularly our coders as well as our people in our hospital business services, et cetera, we have a real opportunity to take a leadership role.

You know, as for the date 2011, as an individual I'm not sure if that's completely reasonable, but I think that my main message is I don't think that

that's a reason not to start. In reality, that migration to ICD-10 has been implemented successfully in most other developed countries.

And so my message to you, and my interest in working with you collectively and potentially individually, is it's time now and let's come together and let's work out the details and get on that road to making the transition that others have already successfully made.

I think with that, those are my initial remarks and there'll be certainly much more discussion in the hour and a half, two hours to come, so I'll turn it back to you.

Ann Palmer: Thank you Dr. Hilborne. Now Pat Brooks, who is Senior Technical Advisor at CMS, is going to provide information about ICD-9-CM, why a new coding system is needed and what characteristics are needed in it, reimbursement and quality problems with ICD-9-CM and benefits of adopting the new coding system.

Pat Brooks: Thank you, Ann. If you'll turn to slide 3, I'll go briefly over the history of ICD-9-CM. It was - ICD-9 - was developed by the World Health Organization for use worldwide. Subsequently, the United States developed a clinical modification which we call ICD-9-CM, and it was implemented in 1979 in the United States.

We basically expanded the number of diagnosis codes from that in ICD-9 and we also developed our own procedure coding system since the WHO did not develop a procedure coding system.

Moving on to slide 4, who are the users of ICD-9? Well, the ICD-9 diagnoses are used by all types of providers in all types of settings. There's only one

official ICD diagnosis coding system. The ICD-9-CM procedures are only used by inpatient hospitals in this country.

And obviously CPT is used for all other settings. Slide 5 asks the question of what ICD-9 used for. A very important thing that Dr. Hilborne just mentioned is that currently it's used to calculate payment, and specifically it's used for the MS-DRGs, the Medicare Severity DRGs.

It's also used to adjudicate coverage. The diagnosis codes are used for coverage decisions in all settings. We use it for compiling statistics and also for assessing quality of care.

Slide 6 points out that ICD-9-CM has become quite outdated. It is 30 years old and the technology has changed a great deal since the coding system was developed. Many categories of ICD-9, particularly the cardiovascular and the orthopedic sections, are full and it has become difficult to add new codes there. It's also not descriptive enough.

Slide 7 discusses why we need a new coding system and there's two important reasons. One of them is for reimbursement. A new coding system would enhance accurate payment for the services provided and also it's important for quality. It would be beneficial to evaluate medical processes and outcomes.

Slide 8 goes over the two important characteristics of a coding system. One is the coding system should be flexible enough to quickly incorporate emerging diagnoses and procedures. It also should be exact enough to identify a diagnosis and procedure precisely - and ICD-9-CM is neither of these.

Slide 9 shows an example of a reimbursement and quality problem with ICD-9-CM and the examples that we've used here are a fracture of the wrist. A

patient fractures their left wrist and then a month later is seen in the same physician's office for a fracture of the right wrist.

Well, ICD-9 does not tell the difference between a left and right wrist so we can't tell if this is the same fracture being treated or if it's a new one of a different wrist.

ICD-10-CM describes left versus right, and also provides additional information - whether this is an initial encounter or a subsequent encounter, and it even goes on to provide information on whether there's routine healing or complications with the healing.

Slide 10 shows another problem that we're really having with the procedure volume. As I mentioned before, many parts of the book are so full it's hard to get new codes into it. There's a code for a combination defibrillator/pace-maker device that isn't even in the cardiovascular chapter of ICD-9, where the other defibrillator and pacemaker devices are.

We had to put this code into the beginning part of ICD-9 in a chapter that didn't exist before then. Coders and researchers who are looking for this and many other kinds of devices, such as spinal devices, are having trouble finding the codes, since they are in various chapters.

We now have two overflow chapters, the second of which is almost full and now soon we're going to be forced to start assigning codes into other chapters such as the eye and the ear. ICD-10-PCS provides distinct codes for all types of devices in an orderly manner and they're easy to find.

Moving onto slide 11, we'll discuss the benefits of adopting a new coding system and obviously the proposed rule is proposing ICD-10-CM and ICD-

10-PCS. These coding systems incorporate much greater specificity and clinical information.

And using a better coding system, we could improve our ability to measure healthcare services. We would also have increased sensitivity when we want to refine reimbursement groups or methods, and we would have enhanced ability to conduct public health surveillance.

We would also have a decreased need for supporting documentation with claims. When the codes don't show enough information, we frequently have to ask for additional information that's submitted in paper claims.

On slide 12, as Ann Palmer just mentioned, we have the Cooperating Parties who will discuss issues from their perspective about moving to ICD-10. I'll be discussing ICD-10-PCS procedure coding systems. Donna Pickett will go over ICD-10-CM, the diagnosis coding system, and we're fortunate to have Nelly Leon-Chisen with American Hospital Association talk about AHA's roles - things they do with ICD-9 and what they plan to do with ICD-10. Sue Bowman from AHIMA is here to discuss their important roles and limitation issues. And you've already heard Dr. Hilborne talking on physician views on its limitations.

Ann Palmer: Thank you, Pat. Donna Pickett, who is Medical Systems Administrator at the Centers for Disease Control and Prevention, is now going to discuss the history of ICD-10, the countries using ICD-10 and ICD-10-CM development, reviewers, major modifications, benefits of enhancements and structural differences.

Donna Pickett: Thank you, Ann. We'll start with slide 14, which provides an overview of the development of ICD-10. It was endorsed by the World Health Assembly in

1990, and that's for diagnosis only. And in 2002 WHO published the ICD-10 in 42 languages, including the 6 official WHO languages.

ICD-10 has been implemented in 138 countries for mortality and more than 99 countries for morbidity. For mortality, which is the reporting using death certificates, the U.S. implemented ICD-10 in January 1999. WHO does not have a procedure coding classification.

Countries that have so far adopted ICD-10 or a clinical modification for use in either reimbursement or case mix include the United Kingdom, which was the first country in 1995, leading all the way to Canada in 2001. Subsequent to 2001, other countries have also adopted or adapted ICD-10 for use in either reimbursement or case mix, including France and others.

For those countries that have developed their own clinical modifications, they have also developed their own procedure coding system, which they used either in their refined DRG system or in their national clinical standards and practice. Some countries have actually adopted some of the case mix or reimbursement systems used by other countries.

ICD-10-CM development - again 10-CM being specific to the United States - we have worked with many providers and we'll show you slides on that shortly. But basically we have consulted with physician groups, clinical coders and other users of the classification, including researchers and quality reviewers.

What we've basically done is gone through a number of years of comments and proposals that have been presented to the ICD-9-CM Coordination and Maintenance Committee, specifically for those concepts that could not be incorporated into ICD-9-CM due to space limitations.

We had several phases of development for ICD-10-CM, which included an open public comment period between the months of December 1997 and March 1998. Though ICD-10-CM is currently not in use for any purposes in the U.S., several countries have either adopted or adapted some of the modifications that have been made in ICD-10-CM. And WHO, which also has an updating process for ICD-10, has also adopted some of the modifications that are currently in ICD-10-CM.

On slides 17 and 18, you'll see a partial list of some of the groups that worked with NCHS, CDC in the development of ICD-10-CM. Later you will hear information about the actual piloting of ICD-10-CM. Some of the major modifications made to ICD-10-CM include changes to the OB codes.

In ICD-9-CM, fifth digits were added to indicate whether the patient was - the encounter was for an antenatal delivery or post partum episode of care. It was determined that these fifth digits - the information provided by these fifth digits - was not clinically useful, and so those fifth digits were deleted from ICD-10-CM.

We've had expansions to the diabetes codes, and we've also expanded a number of sections of the classification, including the injury codes. And let me give you an example of the type of expansion that has occurred. In ICD-9-CM, the concept of open wound includes lacerations with or without mention of foreign bodies, traumatic amputation, puncture wounds with or without foreign body and animal bites. Those specific concepts have been added to ICD-10-CM so that one is able to distinguish between lacerations that have a foreign body or do not have a foreign body or that the open wound actually is an animal bite. Similarly, with the complicated wounds - the concept currently included in ICD-9-CM with mention of delayed healing, delayed treatment, or infection - these concepts have also been expanded out in ICD-10-CM.

Moving onto slide 20, we have added laterality, as Pat had mentioned in her previous slide, so that one is able to determine whether or not an injury or condition is actually on the left side, the right side or whether it is actually bilateral. And slide 20 provides an excellent example of that information being added to the classification.

Other benefits of ICD-10-CM include the harmonization with existing knowledge and classifications currently in use. Chapter 5 in ICD-10-CM has been harmonized with DSM-IV, the Diagnostic and Statistical Manual for Mental Disorders. The classification has also been harmonized with the morphology codes and also with the nursing classification code sets that are currently in use.

Moving on to slide 22 - provides background information on the structural nature of ICD-9-CM. Again, for many of you, you are very much aware that ICD-9-CM is a code set that has either three to five digits.

Chapters 1 through 17, all characters are numeric, and the supplemental chapters start with either an E or a V and are alphanumeric. Examples of this are code 496, Chronic airway obstruction not elsewhere classified; 511.9, Unspecified pleural effusion; and V02.61, Hepatitis B carrier.

In slide 23, in contrast, the structure for ICD-10-CM is different. ICD-10-CM has three to seven digits. The first digit is alpha; it is not case sensitive. The second digit is numeric; digit three is alpha or numeric. And again for alpha, it is not case sensitive.

Digits 4 through 7 are alpha and again not case sensitive or numeric. And we have examples provided in slide 23 that show you the structure of the codes, and I won't read those to you because you have them in your information.

Moving to slide 24, we show one of the other enhancements made to ICD-10-CM, and that is full code titles. If you look at slide 24 and the example in ICD-9-CM, Category 143 is Malignant neoplasm of the gum, 143.0 just says Upper gum, 143.1 just says Lower gum. So you actually need to go back up to the category level to figure out that you are talking about a malignant neoplasm of the gum.

In ICD-10-CM, in contrast, we have actually added full code titles. C03, Malignant neoplasm of gum, is at the category level; however, the specific code C03.0 is Malignant neoplasm of upper gum; C03.1 is Malignant neoplasm of the lower gum. So, all information about the condition is included in that one code title.

Slide 25 provides background information on our Web page and the information that is currently available on the Web page. There is general information about ICD-10 and its use in the mortality death certificate coding.

Also, ICD-10-CM files, information, equivalence mappings, and other related information is available on the CDC NCHS website. At the end of the year, we will be posting the 2008 version of ICD-10-CM which will include updates to the tabular list, the alphabetic index, the general equivalence mappings, and the guidelines. Ann?

Ann Palmer: Thank you, Donna. Now Pat Brooks is going to discuss the development of ICD-10-PCS, structural differences of ICD-9-CM and ICD-10-PCS, advantages of ICD-10-PCS, and impact on Medicare Severity Diagnosis Related Groups.

Pat Brooks: Thank you, Ann. We began developing ICD-10-PCS a good while ago. As mentioned, once again - from slide 27 - that the PCS stands for procedure coding system.

This ICD-10-PCS is designed as a replacement for ICD-9-CM, the procedure codes. It's not as a replacement for CPT. We posted our first version, first complete version of ICD-10-PCS in 1998, a decade ago, and we've been updating it since that time, and currently it's not in use.

Moving on to slide 28, we'll just show you a quick synopsis of ICD-9-CM procedures which have three to four digits; they're all numeric and I give you two examples of the numeric ICD-9-CM procedure codes.

Slide 29 shows how different ICD-10-PCS is. It has seven digits. Each can be either alpha or numeric, and the alpha characters are not case sensitive. We use numbers 0 through 9 but we do not use letters O or I to avoid confusion with the numbers 0 and 1. At the bottom of the page, I show you two examples of the seven digit ICD-10-PCS codes with their level of detail.

Moving on to slide 30, I'll point out a very common code, angioplasty code, 39.50 in ICD-9-CM. That vague code has 1,170 ICD-10-PCS angioplasty codes. And the reason there are so many is because the PCS code tells exactly the artery that the angioplasty is performed on, the approach, and if devices are used such as drug-eluting stent or not. Currently with ICD-9-CM, one would report two or more procedure codes to get this type of information that's found in one very precise ICD-10-PCS code.

Moving on to slide 31, the advantages of ICD-10-PCS are first of all, it provides greater detail on procedures. There's also space for capturing new technology and devices. There's room for expansion. Another benefit is it has

a very logical structure with clear, consistent definitions that you can read about when you read our User Guide on our Web page.

And on slide 32, I show where you can find information on our ICD-10 PCS Web page. We have the complete version of ICD-10-PCS. You can use that interactive version. There's a User Manual that tells you how it was developed along with some explanation of using the system and guidelines.

There are mappings between ICD-10-PCS and ICD-9-CM forward and backwards. And before you use those mappings, you might want to read the guideline that describes how to use those mappings. There's also PowerPoint speaker slides and a technical paper explaining how the system works.

On slide 33, I'll mention that people have asked how difficult it would be if you were updating a reimbursement system such as Medicare's MS-DRGs or other type of systems using the mappings.

There's some concern that maybe this would be difficult. Therefore, CMS undertook the task of beginning to convert the MS-DRGs to and from ICD-9-CM to ICD-10-CM and ICD-10-PCS. We began with the digestive system, that's MDC 6 of the MS-DRGs, and in our recent September 24 through 25 ICD-9-CM Coordination and Maintenance Committee we discussed the activity.

We had a presentation, discussed just how pleasantly surprised we were that using the mapping we were able to convert 95 percent of the digestive MS-DRGs to ICD-10. Some codes required some clinical review to get down to specific code level, but for the most part, the mappings worked extremely well in assisting us to convert our data.

We have tasked our contractor, 3M, with converting the rest of the MS-DRGs to ICD-10 by October 1, 2009. And I would state that the final version, ICD-10 version MS-DRGs would be subject to rulemaking.

But this exercise does show how one can convert data using the mappings that exist at this time. Over time, we would hope that the MS-DRGs could be refined to take advantage of the additional specificity that's available in ICD-10-CM and ICD-10-PCS.

Ann Palmer: Thank you, Pat. Now Nelly Leon-Chisen, who is the Director, Coding and Classification at the American Hospital Association, is going to discuss AHA's roles, plans, and implementation issues regarding ICD-10.

Nelly Leon-Chisen: Thank you, Ann. As has already been mentioned, the American Hospital Association has been involved with ICD-9-CM for quite a number of years, and AHA is one of the Cooperating Parties.

So I'll talk about the Central Office in ICD-9-CM, our role in providing coding education today through our publications, our audioseminar series and speaker's bureau, and then share information regarding our thoughts and plans for ICD-10-CM and 10-PCS education and implementation.

On slide 36, we have a little bit of information about the AHA Central Office on ICD-9-CM. This office was created in 1963 through a Memorandum of Understanding with the Department of Health and Human Services.

The office is housed and supported by the AHA and it serves as a clearinghouse for issues related the use of ICD-9-CM. We receive coding questions from all users and direct responses are provided free of charge.

The questions can range from simple questions related to locating a fifth digit to more complex questions for new conditions or new technology where the classification does not readily provide guidance.

The goal of the office then is to maintain the integrity of the classification system so that the codes can be applied in a uniform and consistent manner by all users.

Moving on to slide 37 - because we get hundreds of letters every month, we quickly became aware of the shortcomings or problems and limitations of the coding system.

The letters that we get can become recommendations for revisions and modifications to the current ICD-9-CM, especially after we bring those issues to the Coding Clinic Editorial Advisory Board and we're not able to find a good match with the existing codes.

We develop educational materials and programs on ICD-9-CM, including audio seminars on hot topics, but our best known resource is the AHA Coding Clinic for ICD-9-CM.

Moving on to slide 38, Coding Clinic has been continuously published since 1984. It is a quarterly newsletter devoted strictly to ICD-9-CM coding. It consists of an Ask the Editor section which has the frequently asked questions received by our office or questions that have never been addressed and that therefore need wider dissemination.

These are real live questions received through our clearinghouse service, and I'm sure many of our listeners on today's call have already sent in questions to us in the past and have seen their questions and answers published in Coding

Clinic. Periodically, we also publish more extensive educational articles in the coding of more difficult scenarios. Some recent examples have been respiratory failure and sepsis.

And then our fourth quarter issue is typically the largest issue of the year. And this contains the ICD-9-CM code updates that come in every October with additional clinical information to help educate our coders on the new codes and examples and how to apply these new codes.

Starting with the third quarter issue of this year, we have introduced a new section on reporting Present on Admission or POA indicators as we work with CMS to develop a process for handling those questions through our existing ICD-9-CM process.

The Coding Clinic publication is supported by the Cooperating Parties and the Editorial Advisory Board so that every issue is approved for publication by these groups. The EAB includes representation from physician groups like the American Medical Association, the American Academy of Pediatrics, the American College of Surgeons, and the American College of Physicians. We also have representatives who are currently employed in hospitals.

On slide 39, we have the major functions of Coding Clinic for ICD-9-CM. And these include providing official ICD-9-CM coding advice because you can rely that every question and answer has been discussed and approved by the Cooperating Parties and the EAB. And we also republish the official guidelines and any changes to those guidelines.

We answer questions on code assignment and importantly also address issues of sequencing of codes which may impact on the information that is submitted, especially as we're looking at selection of principal diagnosis.

We serve as the current reference on regulatory and other requirements for reporting diagnostic and procedural information from medical records. And over time you have seen issues describing what documentation may be used for reporting pressure ulcer stages, BMI, what to do with documentation from different types of providers.

We generally present topics and articles that provide practical information, and again, these are originated from the letters that we do get. And the goal is to improve the technical coding skills of ICD-9-CM users. And as such, we address issues facing ICD-9 users on data reporting requirements, data edits.

So for example, if there are problems with a combination of codes, whether it is possible to use the codes, the two codes together or not, record documentation and other ICD-9-CM related matters.

On slide 41, we talk about the Faye Brown ICD-9-CM Coding Handbook. We believe the AHA's ICD-9-CM Coding Handbook may be the first coding training book that was published in the United States back in 1979. It was developed by the founder of the AHA Central Office. It's a textbook used in many coding and HIM programs around the country, and it's now annually revised by the AHA Central Office staff.

Because we believe ICD-10 to be extremely important to our members and their future, on slide 42 we start talking about what we envision to be our role, what we have done so far in ICD-10 and what we envision our role to be in the future.

We have been actively involved in ICD-10 over the last 20 years and intend to continue to do so into the future. We have participated in the development of

ICD-10-CM and ICD-10-PCS through the technical advisory groups and provided extensive review over the years.

AHA members as well as the AHA Central Office on ICD-9-CM staff participated in real world testing of both ICD-10-CM as well as ICD-10-PCS. You'll hear more details on the joint AHA/AHIMA-led ICD-10-CM field testing from Sue Bowman in a few minutes.

The only thing I would add at this point is that as part of the ICD-10-PCS informal testing, we submitted two years of surgical questions referred to the AHA Central Office on ICD-9 for coding advice. These questions required further referral to the Coding Clinic Editorial Advisory Board because distinct or clear ICD-9-CM procedure codes could not be found.

Where the EAB had been required to spend a significant amount of time deliberating over the correct ICD-CM code selection, the field testing found coders were able to easily and accurately assign an ICD-10-PCS code without any problems. We found the testing overall - they had been thorough and representative of the types of medical records that would be coded under ICD-10-CM and 10-PCS.

On slide 43, just wanted you to know that we have been preparing for ICD-10 for quite some time, so since 2004 the Faye Brown Coding Handbook has contained preview chapters on ICD-10-CM and 10-PCS.

And these chapters provided an overview not only of the code structure and how they compare to what we're familiar with in ICD-9-CM, but also information on how to start preparing for ICD-10 implementation - whether it would be for an individual such as an HIM professional or a coding professional, or if an institution - what kinds of things should be considered,

including checklists on what to review and who to include as part of the implementation process.

So our future plans for ICD-10 include a Central Office on ICD-10, Coding Clinic for ICD-10, Train the Trainer program, as well as education and outreach for hospitals.

We think that the AHA Central Office on ICD-10 would continue to support coding questions through a clearinghouse function, and we would continue to provide direct responses to individual coding questions. And, of course, that information would also be fed through for content into ICD-10 Coding Clinic with the collaboration of the Cooperating Parties.

So we envision that the major functions for Coding Clinic for ICD-10 would continue to be similar to what we currently have for the AHA Coding Clinic for ICD-9-CM and it would continue in the same format, namely, a hard copy subscription or electronic CD or available through encoder products where many of them, if not all of them, already contain Coding Clinic.

We have already started our educational outreach as far as ICD-10, and more recently we have developed a member advisory that went out to all our hospitals and it's also available through our website.

And as far as Train the Trainer programs, we believe that there are going to be many different levels of training, and we're ready to help health information management professionals as they try to explain and talk through the implementation process, whether it is with the senior management at their institutions or working with other departments to try to identify what are the areas that are impacted and how they should go step-by-step working with other departments that would be affected.

We would work with the State hospital associations to try to reach as many hospitals as possible. And the training and education, again, would depend on the role that each individual would play within the facility. Some folks would only need an overview versus in-depth training for coding professionals - depending on the individual role - and the timing would also change.

So for example, in-depth training of coding professionals would be three to six months prior to implementation, but general overviews for folks that are looking at their information systems, trying to determine the impact and trying to budget for it, would be receiving more general overviews earlier in the process.

But it - overall, we do want to emphasize that there needs to be an assessment of what is needed. And individuals would need to identify what their needs are and consider where and how they would purchase their educational resources because we realize, like with so many other new initiatives that hospitals have had to deal with, there will be many offerings. So, we would want to make sure that these offerings come from sources that hospitals and other coding professionals have learned to trust over the years.

On slide 48, we have a summary of the major implementation issues that hospitals should look at for this major initiative. Obviously, budgeting is something that needs to be considered, and it's something that would need to be done over several years because this is a multi-year implementation process that involves different areas.

The areas affected would be personnel training and, again, that would depend on the role of the individuals. Also, you would need to work with medical staff to ensure appropriate documentation is available, not that you need to retrain physicians in order to assign ICD-10 CM and 10-PCS, because we

have seen through the pilot testing that it is possible to assign codes based on today's documentation.

But if we're going to reap the benefits of greater specificity, we need to make sure our medical staff understands what the benefits are of greater specificity so that we can reduce the number of physician queries required in order for us to assign the right codes.

There obviously will need to be a lot of hardware and software changes. And, again, that will vary from institution to institution depending on what systems you have, whether they are best of breed, where they all would communicate together, whether you have systems that are home grown or commercially available.

And then data conversion - not every system would need to be converted and so it would be on case-by-case basis. Then decisions would need to be made as to whether you would want to convert everything that you have, or only as needed, or only as required for specific types of analysis. Again, this is not going to be a one-size-fits-all implementation process.

But for now what you need to do is - moving on to slide 49 - is to start looking at how you're going to tackle this big initiative. Obviously, because this crosses over in multiple departments, you're going to need a cross-functional team.

And this would involve collaboration among the different departments necessary in order to identity which information systems are affected. And these would include members across clinical areas, financial areas, and information system areas.

You may be surprised to find that certain physician clinics, for example, may be having their own databases for a particular study that they're working on. So it's important that everybody is aware of what this change means.

But most of all, there needs to be support or sponsorship from administration to make sure that everyone understands and that timelines are developed. And that there is support for trying to get the budget through and understand where things need to be prioritized. And obviously the HIM department leaders as well as the coders would need to be involved.

Some initial activities at this point would be to conduct a systems inventory - this is the only way you're going to be able to determine where the databases exist, what software programs do you have, where they reside, whether you need to work with your commercial vendors to determine when they would be ready and what their needs are, or whether it's a homegrown or proprietary program unique to your individual facility, and whether you still have the resources available internally to make changes to those systems, or whether external help will need to be acquired, or whether you want to migrate this to something a little more generic that may be able to be integrated with something that you already have from a commercial vendor.

No matter what you do, as you plan for future expansions in your information systems, you need to be sure that your vendors are aware of this change to ICD-10 so you're not surprised later and these systems are not able to accommodate the new system.

As far as timing, we have been recommending that our members start preparations way before this time; actually, before our final rule, before implementation date is set. Don't wait for the final rule because you're wasting precious time.

So in order to even identify how long it will take or what you will need to do, you need to get started right away if you haven't already done that. You'll find that many hospitals may have already done a basic gap analysis some time ago when we thought that the NPRM was going to come out earlier.

But in any case, those plans and those inventories would need to be revisited because things may have changed in your facilities since that time. And once you realize and you decide where things need to change, then that's when you'll be able to get a better idea of what the estimated timeframe for making changes or for making any software upgrades, because it will take time.

It will take time not only to make these changes, but to coordinate this effort across different areas within the hospital. So if you haven't already done so, get your cross-functional teams started. Start thinking about who you need to invite. And again, remember we do have time; you don't have to rush and buy full-blown ICD-10-CM/PCS training at this point.

There will be time to train the coding professionals. At this time, basically you're trying to create the infrastructure you plan in terms of how you're going to proceed.

And we have on the next slide, 52, a number of links directly to the Central Office on ICD-9 CM and a section on ICD-10 where we'll be posting materials and information as we move forward and help you along with the implementation process. Ann?

Ann Palmer: Thank you, Nelly. Now, Sue Bowman, who is the Director, Coding Policy and Compliance at the American Health Information Management Association, is going to discuss AHIMA's role regarding ICD-10 including academic and educational plans, ICD-10-CM and PCS testing and implementation planning.

Sue Bowman: Thank you, Ann. Since coding is a core function of the health information management profession and improving data quality is a key part of AHIMA's mission, we've been committed to working with the healthcare industry to ensure a successful transition to both ICD-10-CM and ICD-10-PCS.

AHIMA has a long history of providing coding education and resources for coders and other health information management professionals working in a variety of healthcare settings.

And in fact, we've been involved with ICD-10-CM and ICD-10-PCS preparation and planning including providing input to the development of the systems themselves, participating in testing of these coding systems, and developing resources for what seems like many, many years now.

In addition to providing education to experienced coding and other HIM professionals, we also developed curricula for associate, baccalaureate, and master's health information management programs.

And as described on slide 54, these curricula are obviously one of the first areas that we need to focus on to make sure they are updated to reflect ICD-10-CM and ICD-10-PCS education.

The HIM curriculum at all academic levels currently already have ICD-10 as a required knowledge cluster, but based on whatever the final implementation date is and the different graduating classes, these curricula will be expanded appropriately to include a greater amount of ICD-10 training as we move closer to implementation to ensure that our graduating students are adequately prepared for the ICD-10 world when they graduate.

We have an Education Strategy Committee that helps us develop transition and implementation strategy to pull ICD-10 coding, reimbursement and change management knowledge clusters into our associate and baccalaureate model curricula.

And we've discovered that it's well beyond just the knowledge clusters for clinical classification systems. There are a lot of other knowledge clusters in our curricula that have to do with data analysis and data management that also are impacted by such a significant change in the coding system.

And our master's level programs also need to be updated to reflect changes in managerial and organizational skills to reflect the types of skills that are needed to work with ICD-10 coding.

We also have a number of coding certificate programs that are approved through AHIMA as well. And these programs will obviously need to be updated to include comprehensive training in ICD-10 in the model curricula for those programs.

We have a Virtual Lab through AHIMA that helps to provide students with real life world experience of working in healthcare settings in a virtual web-based manner. And this - because it's web-based - is very easy to be quickly updated through our vendor partners that work with us on that lab, so we will be able to incorporate ICD-10 into that application relatively quickly.

We will also work with our international colleagues since we actually have an international education work group of educators to take advantage of our colleagues in other countries who have already had the experience of converting to ICD-10 and can advise us on the most successful conversion strategy to move our education system forward to reflect ICD-10.

We have a newly-launched program through AHIMA to help educators take advantage of courses that other educators have already developed - so that different programs don't have to reinvent the wheel all the time, by providing electronically courses that they have developed and then put into a clearinghouse kind of mechanism - so that other educational programs can pull from that database of courses.

And this is also a relatively quick way to incorporate educational courses on ICD-10 and make them available to our various educational programs and distribute ICD-10 information very quickly throughout all our accredited and approved programs.

On slide 58, they're talking a little bit about what is our educational plan for our current HIM professionals and other segments of the industry. Well, we recognize that different segments of the industry - people with different roles - are going to need different types of education.

So we are looking at a targeted educational model for various ICD-10 audience segments that include our members working in various HIM roles - including coders, but HIM management and other roles as well; also executive level leadership positions in different healthcare settings.

And I think that's really important to recognize that a lot of the settings are going to need different types of training depending on how they use the systems and the types of cases that they see.

I've already talked about educators and current students - and then care providers, data managers, and other groups of people that use data but don't actually have to assign the code on a day-to-day basis - they also require some

level of training that is not the same level or the same type as what coders would need.

So we're looking at how do we develop and tailor those types of educational resources to address the very needs of different groups of people who also will have a varying need for different types of training at a different point in time between now and when ICD-10 is actually implemented.

Some of the resources that we already have available include online courses, giving an overview of ICD-10-CM and ICD-10-PCS, an ICD-10 Preview Book.

We've also recently developed an ICD-10-CM Proficiency Assessment that allows people to see where their strengths and weaknesses might be with regards to ICD-10-CM and start preparing for that some of those areas such as anatomy where they might need to be trained now and there's no need to wait until we're closer to implementation.

We'll soon have an ICD-10-PCS Proficiency Assessment. We do have three saved implementation preparation checklists on the AHIMA website. We've given a couple, several audioseminars including a couple of Webinars, as soon as the NPRM came out, that are available on our website.

During our national convention, coding regional meetings, and other educational sessions, we'll obviously be offering conferences, and we've had a number of journal articles over the years on ICD-10.

Our ICD-10 page on our website has a variety of resources and links already, including a rather extensive list of FAQs to provide substantial ICD-10 awareness education as well.

On slide 60, some of the transition resources that are currently in the planning stages that we're starting to work on is implementation guidance tools for healthcare organizations that have to worry about moving to ICD-10.

Our Council on Certification is looking at how to incorporate ICD-10 into our maintenance of credential requirements to ensure that our credentialed members are adequately educated in ICD-10 and demonstrate that level of expertise.

And some of the types of tools that we will be developing for these areas will include toolkits and checklists, talking points, and then as I said earlier, to taking advantage from some of the lessons learned from our international colleagues who have already been through this experience.

Now I'm going to talk a little bit about the testing that has been done for ICD-10-CM and ICD-10-PCS. First, as Nelly mentioned earlier, there was a field-testing project that AHA and AHIMA sponsored to test ICD-10-CM.

The purpose of this project was to assess the functionality and utility of applying ICD-10 CM codes to actual medical records in a variety of healthcare settings and to assess the level of coder education and training required.

This project consisted of 6,177 medical records that were coded by coding professionals working in a variety of healthcare settings. Participants received only two hours of non-interactive training to prepare them to participate in their project.

And yet, coding accuracy was surprisingly good as was their understanding of how to use ICD-10-CM, and determined by a combination of looking at a

validation of a sample of the assigned codes and also reviewing the types of questions and comments that were submitted by the participants.

And it's important to note that these records were - they were not in a controlled environment where we provided standardized medical records to the participants. They actually coded the records in their own organization. So these were actual medical records in their own settings.

And interestingly enough, only 12.3 percent of the reported ICD-10-CM codes fell into the unspecified code category. So even though there's a perception of, Nelly alluded to, that we need to significantly improve medical record documentation in order to assign ICD-10-CM codes, it was surprising that there were so many existing medical records that could still be coded with very specific codes even without making any changes to medical record documentation.

And as part of this project, coders were instructed not to query the physician. They just coded the records the way they were. However, of course, there are areas where some improvement in medical record documentation would improve the coding specificity and higher data quality, but it was still surprising that there were so few unspecified codes.

The participants felt after working on this project that ICD-10-CM was definitely a significant improvement over ICD-9-CM and the ICD-10-CM was much more applicable to all healthcare settings and more useful in today's environment.

The clinical descriptions of the ICD-10-CM codes were thought to be much better then ICD-9-CM and the majority of the participants did think that the

notes, instructions, and guidelines in ICD-10-CM were clear and comprehensive.

One comment that many participants supplied after the end of the project was that they were surprised that ICD-10-CM really wasn't as hard as they thought it would be.

A survey of the participants indicated that two to three days of training for ICD-10-CM was probably going to be adequate, which is consistent with AHIMA's current estimate of about two days for ICD-10-CM training.

And as Nelly noted earlier, it was also felt that training should not occur too far in advance of ICD-10 implementation because people would just have to be retrained when we got closer to implementation if they hadn't been using the coding systems in the interim and that intensive coder training should occur probably around three to six months prior to implementation.

For ICD-10-PCS, formal testing was undertaken by CMS contractors who coded 5,000 medical records from an additional comparison test of 100 records.

Participants in the informal testing received two days of training in the medical and surgical section of ICD-10-PCS and one day of training on the other section.

Informal testing of ICD-10-PCS was also conducted by AHA and AHIMA volunteers. For the results of this testing, it was found that after the initial learning curve, participants were able to use ICD-10-PCS relatively easily.

And while ICD-10-PCS requires a greater understanding of anatomy in some areas, we believe that the body part key being developed to accompany ICD-10-PCS would help with this since this key will translate anatomical sites likely to be documented in the medical records, such as a specific bone to the body part terms used in ICD-10-PCS.

So, for example, you could easily determine if a particular bone should be appropriately classified to the hand versus the wrist. Participants in the ICD-10-PCS testing thought that, not surprisingly, it's much more complete than ICD-9-CM with significantly greater specificity and that the precision of the codes resulted in much greater detail about the nature of the procedure, that it was much easier to expand the system, and that the multiaxial structure made it very easy to analyze data from.

It was also felt that, in spite of the fact that ICD-10-PCS looks so different from ICD-9-CM and so people assume it's going to be difficult to learn, the fact that it uses standardized terminology makes it easier to use once the coder has grasped the initial concept and design of the system and the definitions and the terms.

And that having all the terms defined really makes it a lot easier both to teach it as well as for people to learn it. And currently AHIMA estimates probably approximately three days will be needed for ICD-10-PCS training.

On slide 62, let’s spend a few minutes talking about AHIMA’s implementation planning recommendations. The first stage of preparation involves assessing the impact of the change and identifying key tasks and objectives.

An interdisciplinary steering committee to oversee ICD-10 implementation should be established, and this steering committee should develop organizations' ICD-10 implementation strategy and identify the actions, people responsible, and deadlines for the various tasks required to complete the transition.

This implementation plan should include estimated budget needs for each year leading up to implementation, as well as any anticipated post-implementation budgetary issues, such as additional training needs or the needs for contractors to assist with coding backlogs.

An internal timeline with the associated resources required should be developed. ICD-10 awareness training should be provided to everyone throughout the organization that would be affected in any way so that they are aware of the coming transition and what it means for them and can start evaluating the impact on their areas of responsibility and any budgetary implications.

Staff education needs should be assessed, such as who needs education and what type of and level of education do they need, what method of education would work best for different categories of people in terms of effectiveness of training as well as cost.

And it's not too early to start looking at the medical record documentation and identify areas where strategies should be instituted today to improve that documentation and preparation for transitioning to ICD-10.

As Nelly also indicated, AHIMA also recommends that it's time to get started now if you haven't already done so. Don't wait for the final rule, take advantage of any additional time here to go ahead and get started because

there are a lot of steps to this first impact assessment phase that are not going to be wasted regardless of what the actual final implementation date turns out to be.

Start looking at strategic implementation and organizing the required resources to implement the transition plan, evaluating the financial impact, starting to develop objectives for moving forward, timeline measurement tools, evaluation strategies, and the action steps for each phase as moving towards implementation.

The extent of changes to systems, processes, and policies and procedures need to be assessed and the changes that will need to be made to the various systems and applications that use ICD-9-CM codes or coded data in any way will need to be assessed.

For example, a comprehensive systems audit for ICD-10 compatibility needs to be performed. This would include performing an inventory of all the databases and systems applications that use ICD-9-CM codes, giving consideration to how those codes are used in each system and where the codes come from.

For example, are they manually entered versus imported from another system, looking at how the quality of data in those systems is checked and what is going on in the interfaces between the systems, software changes including field size expansion, alphanumeric code composition, redefinition of code values in their interpretation, and edit and logic changes need to be identified as well as any new or upgraded hardware or software requirements in the associated budgetary implications.

Examples of some of these systems and applications that might need to be evaluated because they incorporate ICD-9-CM codes to some extent are listed on slide 64, but this is certainly is not an all-encompassing list of systems.

All the reports and forms that include ICD-9-CM codes will need to be identified because they will need to be modified to accommodate ICD-10-CM and/or ICD-10-PCS codes depending on the type of information that's on that form.

And on slide 65 is an example of part of a physician practice superbill that has been converted to ICD-10-CM codes to just show how it might look a little bit different once ICD-10-CM is implemented.

And now I'll turn it back to Ann.

Ann Palmer: Thank you, Sue. At this time we will answer participants' questions regarding the topics presented during today's call. Please note the questions about the ICD-10 Notice of Proposed Rulemaking and specific coding questions are outside the scope of this call. Alisha, could you please open the phone lines now?

Operator: Yes, ma'am, absolutely. At this time I would like to remind everyone if you would like to ask a question, please press star then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. We'll pause for just a moment to compile a Q&A roster.

The first question comes from Denise Windom. Your line is open.

Ann Palmer: Denise, are you there?

Operator: Ms. Windom, your line is open. Ma'am, should I just go ahead and move to the next question?

Ann Palmer: Yes, please go on to the next question.

Operator: The next question comes from April Allen. Your line is now open.

April Allen: Yes. I had several staff members here, we were really looking forward to the conference call; however, the slide show that we got from the website had nothing to do with what you all were talking about.

Ann Palmer: This is Ann, and you may have gone to the Coordination and Maintenance Committee Meeting PowerPoint presentation which is on the same Web page; however, if you go to the CMS Sponsored Calls Page, you can see in the Downloads section there is where our PowerPoint presentation is for this call. We apologize for any confusion.

April Allen: Will the same type of information be on the next two meetings that you're doing in November? Or are you going to do different ones?

Ann Palmer: Yes, we will be doing the very same PowerPoint presentations at those.

April Allen: The very same ones. Okay, we may just come to one of those then.

Ann Palmer: Thank you.

April Allen: Okay, thanks.

Ann Palmer: Can we have the next question?

Operator: The next question comes from Edith Sunderland. Your line is open.

Edith Sunderland: Yes, with ICD-9-CM diagnosis codes and ICD-9 procedure codes, there was a very visible, distinct difference in that you could see the procedure codes were two digits and then followed by a period and maybe two more, and the diagnosis codes were three digits. Is there any clear, discernable difference between ICD-9-CM and ICD-10-PCS that we can see visually?

Pat Brooks: This is Pat Brooks. One easy way to know that it's a ICD-10-PCS is that you'll know that it's always seven digits long.

Edith Sunderland: Always?

Pat Brooks: Always.

Edith Sunderland: And I noticed there's no period, is this always the case?

Pat Brooks: That's true, so those are very helpful. In addition, ICD-10-CM, some of the codes are seven digits long, but not all of them.

Edith Sunderland: Okay.

Pat Brooks: And there may also...

Edith Sunderland: The second part of that question, in recognizing differences, you said in the ICD-10-PCS you cannot use the 0 and the 1 so you don't confuse them with the O and the I. Is that the same in ICD-10-CM?

Donna Pickett: No it isn't. When WHO developed ICD-10, upon which 10-CM is based, they did use as the first digits all alpha characters A through Z.

Edith Sunderland: Okay, thanks.

Ann Palmer: Thank you.

Operator: The next question comes from Karen Gern. Your line is open.

Karen Gern: Yes, hello. My question is for Pat Brooks. I'm wondering on the slide about MS-DRGs. I guess it’s a little bit surprising that there was so little difficulty with the mappings there available now, and I'm wondering if there's anywhere else with more details about this. And also if you know if this was just a medical branch of the digestive system?

Pat Brooks: That's a very good question. We only started with, we picked one - the digestive part - and so one hopes that it'll be equally, work as well as the rest of the body systems. But, we will know by the end of October 2009 whether there are problems with the rest the systems.

You can read the slides that go in great detail with the ICD-9 Coordination and Maintenance Committee Meetings, if you'll click on the left side there are links to those and you can see the presentation I'm talking about in great detail.

And you can see how, for the diagnosis in particular, we had even greater ability to replace all the codes and update the DRGs. There was slightly less ability with the procedures. But still, we were averaging 95 percent. And, frankly, we were surprised, too. The mappings are quite detailed and were quite useful.

The things that we learned from those, we've planned to take and automate the conversion of the rest of the parts of the MS-DRG. So, hopefully, they'll even

go faster than the first one where we were learning. But, we will be providing updates on this information at future Coordination and Maintenance Committee Meetings.

We'll keep everybody informed as we move along on this. And then obviously before we would - if a decision is made to implement ICD-10 - and then we converted the MS-DRGs, then people would get to comment on the details of those ICD-10 versions of the MS-DRGs.

But, as you said, we were very pleasantly surprised at how well the mappings were. It was like a search and replace tactic we used. We assigned an ICD-9 code, go to the mappings and find the ICD-10 codes that mapped there and simply replace them and look at how well they worked out.

Trying to keep the general logic, the patients who would be coded with ICD-9 and ICD-10, they should go to the same MS-DRG. That was the goal and that was what we achieved very well.

Ann Palmer: And you can find that information at www.cms.hhs.gov/ICD10. And, as Pat mentioned, on the left-hand side of that page, there is a sentence there called Coordination and Maintenance Committee Meetings. When you select that and scroll down, you'll see in the Downloads are the MS-DRG PowerPoint.

Karen Gern: Okay. Okay, thank you.

Ann Palmer: Okay.

Operator: The next question comes from Sharon Gilbert. Your line is open.

Sharon Gilbert: My question is about ICD-10-PCS versus CPT. Since, for hospital outpatient coding, since PCS seems to be so extensive, has any consideration been given to replacing CPT with PCS eventually for hospital outpatient coding?

Pat Brooks: This is Pat Brooks, and no, we discussed in the proposed rule, and you might want to read in that section where we proposed replacing only the ICD-9 procedure codes with ICD-10-PCS. And we do not propose at all replacing CPT or alphanumeric HCPCS with ICD-10-PCS. And you can read all about that in the proposed rule.

Sharon Gilbert: I did read about that in the proposed rule, but I was wondering why we wouldn't want to have only just the one major coding system instead of both?

Pat Brooks: And, once again, there's information in there about early evaluation of that whole process and why we decided not to propose a single coding system. I guess I don't know more what to say than that.

Sharon Gilbert: Thank you.

Ann Palmer: Thank you.

Operator: The next question comes from Lisa Noldward. Your line is open.

Lisa Noldward: Hello, ladies. I was just wondering as we've listened today, particularly as we listen to Sue talk about implementation and strategic planning, is a tentative date still 2011? Do we have a target?

Pat Brooks: We can't really discuss anything besides saying in the proposed rule, we've proposed for comment 2011. The comment period closes on October 21st.

People can write in and say if they agree or disagree with that date, but we have no final decision. The comment period is still open.

Lisa Noldward: Alright. Thank you very much.

Operator: The next question comes from Scarlett Rooker. Your line is open.

Scarlett Rooker: Thank you. I have actually a three part question that's all related to AHIMA. You have addressed different AHIMA things throughout for education purposes. Will that be open for nonmembers to view those education pieces?

Also, what's going to happen with those certifications that AHIMA now offers with the CCS and CCS-P? Will that go away? Will that still be honored?

And also, are you planning to give CEUs for today's seminar?

Sue Bowman: This is Sue, and regarding your last question, I'm sure this program qualifies for CEU credits. We didn't seek prior approval but, of course, you can go to programs that don't necessarily have prior approval and still submit them as long as it's within the guidelines of a HIM-related topic and, you know, this certainly, certainly is.

Regarding the educational resources, the free Webinar I mentioned is available to nonmembers on our ICD-10 Web page. All of the resources that are on our ICD-10 Web page are available to anyone.

Regarding the maintenance of the credentials, how that's going to be incorporated into our credential has not been determined. That's within the scope of our Council on Certification.

So, we're still looking at that issue, but I believe before the end of this year, they will be coming out with their plan of what the changes in the credential maintenance requirements will be to incorporate ICD-10. Does that answer all your questions?

Scarlett Rooker: I think so, but one other question. You were talking about the resources that you use to make some decisions such as the American College of OB/GYN and so forth.

I know there's probably an intensive list that you have, but you mention a cardiac procedure, but you didn't mention the American Society of Cardiologists or Cardiothoracic Surgeons or anything in Internal Medicine. So I'm sure, though, that you did get in touch with these gentlemen, or these physicians, group of physicians?

Donna Pickett: Are you referring to the diagnosis ICD-10-CM?

Scarlett Rooker: Yes, actually, for your surgical as well as for your ICD-9, ICD-10-PCS.

Donna Pickett: Okay, on the diagnosis side, the two slides that were in my presentation were just representative and are the list of partial reviewers. It does not give you the full flavor of all of the groups that we work with.

Scarlett Rooker: Okay.

Pat Brooks: And this is Pat Brooks. We did work through the AMA, the American College of Surgeons, to get them to assist us with the specialty groups looking at the early developmental part of ICD-10-PCS, so it was widely circulated.

And, frankly, we continue to get input and comments each year since we update it every single year. So, yes, we received and solicited input from a wide variety of practitioners.

Scarlett Rooker: You know I just think it's going to be such an overwhelming implementation, considering that MACs and RACs and all those other attacks are coming at us. It's just very hard for a hospital to keep up with everything this day and time.

And I know we do need a new coding system, so don't say I'm negative. I'm not. We do need the new coding system, but I think we need to take other things into consideration as well.

Pat Brooks: Well, thank you, and we welcome any comments anybody has during the open comment period.

Operator: The next question comes from Paula Royal. Your line is open.

Paula Royal: Thank you. I was very encouraged to hear, I think Sue mentioned about the success of the people that were testing the records. I was just curious, what about productivity? I'm sure at first it was probably a little bit slower, but over time did they increase back to their normal speed with ICD-9?

Sue Bowman: This is Sue and the coding productivity actually for certain, I think nearly half of the records actually wasn't much different for ICD-10-CM and I think for ICD-10-PCS, it was slightly longer than ICD-9.

One of the reasons we didn't focus a lot on the productivity aspect of the ICD-10-CM field testing project was because it was a little bit not realistic of the real world in that there were no ICD-10 code books available.

There were no encoding systems so it was a little bit more difficult to actually do the coding, which obviously affected the productivity, but was not the way it would be in real life once ICD-10 is implemented.

Paula Royal: We wouldn't feel too much pain then with the end billed account when it starts. Is that...

Sue Bowman: Correct.

Paula Royal: Is this somewhat of a learning curve, down productivity...

Sue Bowman: Right. Well, we expect - and this was also what was outlined in the proposed rule and it was also AHIMA's opinion as well - that we do expect that there will be a drop in coding productivities for the first six months.

It just makes sense when you're learning something new, it's not going to be quite as fast as using a system that you've been familiar with for many years. And that's also consistent with colleagues in Canada and other places that also said about a six-month learning curve, and then after that, returning to at least the previous level.

And we sort of actually anticipate that it might be better than the previous level, just because the specificity, the standardized terminology, the definitions may actually turn out to make ICD-10-CM, ICD-10-PCS much easier to code once people are familiar with the systems. It's because of the ambiguity that you have in ICD-9.

Nelly Leon-Chisen: And this is Nelly, I want to echo Sue's assessment. I also agree that once people start using it, you will quickly see that it's not as difficult as some may have thought. So initially, yes, like with any change, there will be a drop in

productivity but, you know, keep in mind that the volunteers are a part of the field testing; were not coding for, you know, as a full-time job.

This was on a volunteer basis, and yet everyone thought that it was easy to learn. And so when you consider what you go through today, trying to match up codes that are vague, that don't fit and trying to kind of match it up with the documentation, I think you'll find that ICD-10-CM and 10-PCS are much easier to learn and use.

Paula Royal: Thank you, that's very encouraging.

Ann Palmer: Thank you.

Operator: The next question comes from David Wilson. Your line is open.

David Wilson: Hi, my question was related to the HCPCS codes. I know it was mentioned that ICD-10-PCS was not intended to replace CPT codes, but what about HCPCS codes?

Pat Brooks: It also is not intended to replace HCPCS codes, so to say the opposite, we would continue using the CPT and HCPCS. If we implement ICD-10-PCS, it would only replace the procedure part of ICD-9-CM, so it would only be used for inpatient hospital coding for procedures.

David Wilson: Thank you.

Ann Palmer: Thank you.

Operator: The next question comes from Ann Watts. Your line is open.

Ann Watts: Hi. I actually have two questions. The first is, can ICD-10-CM be easily mapped back to ICD-10 if one wanted to compare U.S. with international populations? And then my second question is, when will the ICD-10-CM code books be published?

Donna Pickett: Okay, well, let me start with your second question first about the publication of ICD-10-CM code books. Currently, the government does not publish code books. We currently make available ICD-9-CM using a CD-Rom which has a Folio search engine attached to it.

Our plan is to offer ICD-10-CM in the same way, but ICD-10-PCS would also be included on that CD-Rom. As we currently do in ICD-9-CM, the CD-Rom includes diagnosis and procedures.

To your first question regarding the mapping of ICD-10-CM back to ICD-10 - yes, it is easily done. There are some things that are slightly different. We had contemplated mapping in that direction from 10-CM back to 10.

We've not had a number of requests for that. However, if that is something that you would be interested in making a comment on during the open comment period, I think that would be useful.

Ann Watts: And as a follow up, do we know now when the disc with ICD-10-CM and PCS is going to be published, released?

Donna Pickett: Not likely until after there is a final rule.

Ann Watts: Okay.

Pat Brooks: And let me mention one other thing, we have the complete systems available, now on our website, so you can actually go and code interactively right now ICD-10-PCS on CMS' website.

You can also go to CDC's website, and you can find the index with tabular. And I'll mention one other thing - it's up to publishers when they publish books, but we did see a complete ICD-10-CM and ICD-10-PCS just today, that we saw.

So we know some publishers already have books out. And those at the convention that are walking around, I don't know if Nelly and Sue have any information, to see if there are a variety of publishers who have already gone to publish books yet.

Nelly Leon-Chisen: This is Nelly, I have seen a couple on the shelves on the AHIMA annual meeting in the exhibit hall, but I haven't had the chance to review them.

I do want to add, though, that the files that are currently available on the CMS and the NCHS website are very helpful, and I myself used them a number of times when we prepared some ICD-10 information.

And some of you may have participated in the audioseminar that Sue and I did back in May where we took examples from Coding Clinic; they had been published with samples on a stroke coding, I believe, and diabetes and some other ones.

And in order to convert them to ICD-10-CM and ICD-10-PCS, we've basically used those existing public files. So they are very useful.

Ann Watts: Thank you.

Operator: The next question comes from Sharon Lowe. Your line is open.

Sharon Lowe: Thank you. You mentioned that 3M will be mapping the DRGs to the ICD-10. Do you know if they also have plans to map the pediatric, the APR DRGs to the ICD-10?

Pat Brooks: You know, I can't comment on that because that's not a Medicare system software. You probably just have to ask them separately that question.

Sharon Lowe: Thank you.

Pat Brooks: We're mainly focusing on our own payment system at this point, which is the MS-DRG.

Sharon Lowe: Thank you.

Operator: The next question comes from Catherine Minnen, your line is open.

Catherine Minnen: Yes. I was wondering about the AHA Coding Clinic for ICD-10 - whether any of the past guidance from the Coding Clinic for ICD-9 would be republished in the ICD-10, Coding Clinic for ICD-10?

Nelly Leon-Chisen: This is Nelly. That's a decision that the Cooperating Parties haven't discussed yet. Just off the top of my head, I would think that ICD-10-PCS, the procedure side, is very different so we probably would not be able to use that unless we do a conversion.

There is a possibility that some of the clinical examples could serve as a basis to start out kind of showing you the comparison of how it looked like in ICD-9 and what it would look like in ICD-10, but that's something that the Cooperating Parties will need to discuss and determine - the utility of such an

exercise, whether we do it on the top 100 diagnoses or something like that, in procedures or do we need to do it across the board.

Catherine Minnen: Okay. Thank you.

Sue Bowman: This is Sue, and I would concur with Nelly. In fact even on ICD-10-CM, because of some of the structures of the codes and differences, it's more difficult to apply - advice that applied to a totally different coding system, and we've actually been looking at some of our products at AHIMA to see, well, do we just convert some of our existing examples to ICD-10.

And we've discovered that that does not work very well because the case scenarios don't necessarily have the information in them that you would need to assign the ICD-10 codes even though that information might have been in the underlying medical record, for example, left versus right. And so it was actually more difficult to use existing scenarios than to start over with new scenarios and just start with a clean slate.

Catherine Minnen: Great. Thank you.

Operator: The next question comes from Stacy Murphy. Your line is open.

Stacy Murphy: Yes. Hi. Good afternoon. I actually have three questions. The first question pertains to the implementation date. With respect to the implementation, will your systems allow claims with historic data to crosswalk with ICD-10 or will we still continue to be allowed to submit claims with the ICD-9 and counter-data? That's my first question.

My second question is, I think I heard you mention that the subsequent presentations that you have scheduled for next month will be the same exact

presentation as today or will it be specifically geared towards payers and physicians?

And then my last question is regarding the ICD-10 field testing that you did back in 2003. I was just wondering - what was the rationale for only selecting coders that were part of AHIMA as opposed to maybe having coders from other coding professional organizations such as AAPC and others.

Pat Brooks: This is Pat Brooks. I'll do the first two. The first issue, the proposed rule, we have proposed an implementation date and we proposed to do that date of service, would change to a new coding system. So they would be - you wouldn't be choosing to submit whichever ICD-9 or 10 you wanted to choose - is the way we proposed it. We are soliciting comments on that issue now. The second issue is, yes, we will be presenting the same presentation that you have in front of you at the next subsequent call, so it will be the same.

On the field testing, I'll defer to Sue on that one except to say that when we did our field testing ourselves with our contractors, we used our own contractors to do ICD-10-PCS and they happened to be credentialed by AHIMA. And Sue did you want to comment on the AHIMA one?

Sue Bowman: Yes. Actually we had way more volunteers then we could even use, and so since AHIMA was helping to sponsor it, we ended up having to limit it to AHIMA members. But the other part of that was to facilitate the administrative process for the project and limit the cost of the project.

We used our communities of practice mechanism for communicating with the participants and posting questions and dealing with the management angle of the participation in the project, and unfortunately, right now our community as

a practice communication mechanism is limited to AHIMA members. So that was actually really the primary reason.

I don't know if Nelly has anything to add, but...

Nelly Leon-Chisen: No, the only thing I would say is that these - the participants were self-selected and so some of them were also working in other settings. So although the credentials are all AHIMA credentials, the participants also worked in outpatient settings, physician practices, home health, hospice, so to the extent that there may be folks out there that have dual credentials, some of them may have been part of this pilot test as well.

Sue Bowman: And that's a good point. We actually know of circumstances where there were settings where the primary participants might have been credentialed by AHIMA but they actually have some of their staff working on some of the records, and so that didn't really get folded into the data because we had sort of a primary participant listed.

But we didn't necessarily know for sure if there was anyone else doing any of the coding of records. But pretty much all the range of healthcare settings was represented, everything from different outpatient settings to mental health clinics to rehab facilities to long term care facilities to home health agencies, physician practices, et cetera.

Operator: The next question comes from Davita Hunter. Your line is open.

Ms. Hunter, your line is open.

Davita Hunter: Hello.

Ann Palmer: We're here.

Operator: Ma'am should I just move onto the next question?

Davita Hunter: Hello?

Ann Palmer: Hello.

Davita Hunter: Okay. I'm sorry.

Ann Palmer: That's okay.

Davita Hunter: I was just wondering, you said when you did the pilot study that you didn't - first you said you hadn't published any books on ICD-10 or any software. How did they do the study?

Sue Bowman: They used - this is Sue - they used the files that we talked about earlier that are currently on the NCHS and CMS websites. Those files were available at that time, so they could use those files for the coding.

Davita Hunter: And these files contained all of the codes that are in ICD-10 and PCS?

Sue Bowman: Yes.

Davita Hunter: Oh, okay.

Sue Bowman: In that - it's the entire system including the index and the tabular components.

Davita Hunter Okay. Could you tell me about how many pages that is because I wanted to print it out.

Pat Brooks: This is Pat Brooks. I don't know that you'll necessarily want to print it out. Maybe if you wanted paper you could look at the publishers who I believe are now publishing these books.

But if you go, for instance, to our CMS website and you want to use ICD-10-PCS, you could see how easy it is just by clicking on the index, finding the right code and it takes you right over to the tabular. It gets you the right section so you could bill the codes.

We didn't go into great detail about this, but it walks you through creating a seven digit code. So try that first and I think you'll find that very helpful and, as I said today, I did see one publisher that has both books out in paperback. It's not that I would endorse one versus the other, but I believe if we get a final rule out and we have an implementation date, more than likely many publishers will choose to publish books.

I believe there has been a reluctance on their part, perhaps because no final decision has been made as yet if we are going to go to ICD-10.

Davita Hunter: Okay.

Pat Brooks: But the tools are all there on the Web page, and they are all free.

Davita Hunter: Great. Thank you.

Ann Palmer: Thank you.

Operator: The next question comes from Gayle Scott. Your line is open.

Gayle Scott: Hello. Yes. I wanted to compliment Sue on all the information that she provided on the implementation planning but I can tell you, as she was speaking, my mind was exploding because it wasn't on the slides. All the things that she touched on, it really had to be considered and thought about. I'm just wondering if she would be willing to share her notes.

Sue Bowman: Well the transcript of this session will be available on the CMS website.

Gayle Scott: Okay.

Sue Bowman: So, everything that we said, even if it wasn't on the slides will be included in the transcript. So...

Gayle Scott: All right.

((Crosstalk))

Ann Palmer: If you go out on the ICD-10 page, and if you select the CMS Sponsored Calls on the left, it will be in the Downloads section.

Gayle Scott: Okay.

Ann Palmer: So shortly after this call we will post it there.

Gayle Scott: Thank you very much.

Ann Palmer: You're welcome.

Operator: The next question comes from Banner Health. Your line is open.

Banner Health: Hi. This is along the lines of some previous questions, but is there currently a crosswalk from ICD-10 to ICD-9 anywhere?

Pat Brooks: Yes, there's crosswalks from ICD-9 to ICD-10 and from ICD-10 back to ICD-9 for both the procedure and the diagnosis codes. And on our Web page, if you look at the very back of your resources in the handout today, you'll see for instance on the CMS website, we have those mappings.

We call them general equivalency mappings. And there's a Guide Book that tells you how to use those. So if you want to start converting your data or looking at it, you can do that now, starting - going from 9 to 10 or 10 back to 9.

Banner Health: Thank you.

Operator: The next question comes from Patricia Bowling. Your line is open.

Ann Palmer: Did you have a question?

Patricia Bowling: Our question was already answered. Thank you.

Ann Palmer: Thank you.

Operator: The next question comes from Mitzi Ford. Your line is open.

Mitzi Ford: Yes. We actually have a coding program that's approved by AHIMA where we partner with several of the hospitals and they hire a lot of our coders.

If the implementation date is 2011 - Sue, I guess this question is for you, do you see that the students in the program for 2010 - 2011 would in fact be taught the ICD-9 and the ICD-10?

Sue Bowman: Yes, I don't have the actual educational plan in front of me, but I know there's sort of a sliding approach where, you know, there's a little bit of ICD-10 and then there's more ICD-10 and so forth up until implementation, so that in the couple of years just prior to implementation, the students would be receiving more comprehensive training on ICD-10-CM and ICD-10-PCS.

But, of course, they would still need some level of ICD-9-CM training because there's still a lot of data in that coding system as well. And so at the time of implementation, they would need to know both. So we are working on...

Mitzi Ford: I'm sorry. I guess my concern is for coders who know ICD-9 system. I would assume that the implementation and the productivity and that kind of thing would be minimal. But for those who are learning both, it seems like it would be an information overload.

Sue Bowman: Yes, and that's something we're trying to balance - that our educational program staff are looking at - is sort of how much of each to incorporate and to sort of balance it because you're right, there's only so much time in the program. But, that's what they're working on right now.

Mitzi Ford: Okay. Thank you.

Operator: The next question comes from Danita Sulvik. Your line is open.

Ann Palmer: Danita, did you have a question? Alisha, let's go on to the next question, please.

Operator: Yes, ma'am. Next question comes from Bob Starling. Your line is open.

Bob Starling: Hi. Yes, we had a question. We were wondering whether - when the - does the proposed rule address whether the ICD-10 will be mandated on claims, paper claims as well as electronic claims?

Pat Brooks: This is Pat Brooks. It would become a national HIPAA standard for all, for all reporting, yes.

Bob Starling: Well, the HIPAA standards only apply to electronic transactions, so I specifically am asking regarding paper claims, those that are submitted on paper bills forms.

Pat Brooks: Yes, but let me just say this. Yes, if it is adopted, it would become effective for all reporting in the United States on the date that it was implemented. So, those who code any place and submit paper or electronic on the date that was selected would be using ICD-10 and no longer would we maintain ICD-9.

Bob Starling: Okay. Thank you.

Operator: The next question comes from Dubrama Abromovic. Your line is open.

Dubrama Abromovic: Hi. Our question was answered.

Operator: The next question comes from Beth Alvarado. Your line is open. Ma'am, she has withdrawn her question. I'll move on to the next question.

Ann Palmer: Thank you.

Operator: The next question comes from Joanna Hussein.

Joanna Hussein: Hi. We're currently on electronic health record and I was wondering if you knew if any vendors that are prepared for this ICD-10 conversion?

Pat Brooks: All right. I don't believe we have information about various vendors.

Joanna Hussein: You do not have any information? Because we're a pretty large organization and we were wondering, you know, how do we go about converting to ICD-10 and what are the - and if you have any idea about how to go about it, a lesson plan. Could you share that with us, please?

Pat Brooks: That's probably Sue. You talked about some of that in your presentation. Do you want to summarize for her what AHIMA's learned?

Sue Bowman: Well, in answer to her question about specific vendors - I don't have a list of vendors and what stage of implementation they're on. There are obviously some that are further along perhaps than others.

But we do, we do have - and this is what I was alluding to in my presentation - we have an implementation preparation checklist on the AHIMA website, which is available to both members and nonmembers as well as information I provided during the slides about starting to do an impact assessment and going through your various systems and applications to determine where you use ICD-9 codes and where that's going to have to be updated.

And then looking at your different departments and staff and who looks at coded data and uses reports that have coded data and is going to require some kind of training.

But as we move forward and as we get a final rule, you know, there will be a lot of different organizations that will be putting out a lot of tools and other resources to help organizations move forward with the implementation process. Does that answer your question?

Joanna Hussein: Yes. Thank you so much. I know your national seminar is going on in Seattle. Are you addressing anything? Because our managers have gone there, you know, so I'm wondering if they could come back with a wealth of information on ICD-10.

Sue Bowman: Yes, I am in Seattle and we do have several ICD-10 presentations on the agenda and, in fact, we're having an ICD-10 town hall meeting this afternoon to address a lot of people's questions as well.

Joanna Hussein: Oh, great. Thank you so much.

Nelly Leon-Chisen: This is Nelly, if I may just add at this point, I don't want to create the impression that if you have any systems today that you have to ditch them and look for a new vendor.

I think your first step would be to contact the vendor that you currently have for your EHR or any other systems and find out what their plans are because you may be surprised that some of them may have already been thinking about it or if they have already started planning, they may have an idea of whether they can support your systems or not.

So I don't want to leave people on the line with the impression that you need to replace everything that you have because your current vendor may be and probably will be willing to support you.

((Crosstalk))

Ann Palmer: Alisha?

Operator: Yes ma'am.

Ann Palmer: Alisha, we'll take one more call, please.

Operator: Yes, ma'am. The next question comes from Sharon Ruche. Your line is open.

Sharon Ruche: Withdraw that question.

Ann Palmer: We can take one last call, please.

Operator: The next question comes from Ronald Helstern. Your line is open.

Ronald Helstern: Yes. In ICD-9 there is some stratification of chronic disease status stable or unstable or controlled and uncontrolled. Is there anything like that in ICD-10?

Pat Brooks: Controlled and uncontrolled.

Donna Pickett: Ask him to repeat the question.

Ann Palmer: Sir, we're having a little bit of technical difficulty hearing you. Would you be able to repeat your question?

Ronald Helstern: Yes. In ICD-9, there is some stratification of chronic disease status, the 250.01, 02 codes, Diabetes controlled and uncontrolled. I'm wondering if ICD-10 expands on that at all?

Donna Pickett: This is Donna Pickett. There are expansions to the diabetes codes in ICD-10-CM; however, the concepts of controlled, uncontrolled are currently not

included in version 2007 of ICD-10-CM, and that is based on clinical input that we received regarding the clinical accuracy or lack thereof of the meaning of uncontrolled and controlled.

Ronald Helstern: Thank you.

Ann Palmer: And that concludes our call today, and we thank you very much for your participation.

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

END