Preparing Physicians for ICD-10 Implementation
National Provider Call
Moderator: Leah Nguyen
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Contents

Operator: At this time, I'd like to welcome everyone to today's Preparing Physicians for ICD-10 Implementation 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.

I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

Announcements

Leah Nguyen: Thank you, Holly. I am Leah Nguyen, from the Provider Communications Group here at CMS and I will serve as your moderator today. I would like to welcome you to this National Provider Call on Preparing Physicians for ICD-10 Implementation. HHS has announced the final rule that delays the ICD-10 compliance date from October 1st, 2013 to October 1st, 2014. Now is the time to prepare.

During this ICD-10 National Provider Call, Dr. Ginger Boyle, a practicing family physician who has developed a coding educational program for Spartanburg Regional Healthcare System in its family practice residency program, will share her success and some practical advice about the SRHF transition to ICD-10.

CMS subject-matter experts will also present the latest information and updates from their areas, followed by a question-and-answer session. Before we get started, I have a few announcements. The slide presentation was hosted yesterday on the CMS Fee-For-Service National Provider Call's Web page at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the Web page, select “National Provider Calls and Events.” Then select the October 21st call from the list.

This call is being recorded and transcribed. An audio recording and a written transcript will be posted soon to the National Provider Calls and Events section of the CMS Fee-For-Service National Provider Calls Web page.

And last, please be aware that continuing education credits may be awarded by the American Academy of Professional Coders, the American Health Information Management Association, and the American Medical Billing Association for participation in CMS National Provider Calls. Please see slide 65 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-mails.

At this time, I would like to introduce Dr. Ginger Boyle, from Spartanburg Regional Healthcare System. She'll share some practical pointers for providers on transitioning to ICD-10.

Presentation

Ginger Boyle: Thank you very much, Leah and Holly.

Good afternoon, everybody. I am going to touch some on the preparing physicians for ICD-10 implementation and we are going to go through some of the slide sets that you all have as we touch on “Transitioning to ICD-10: Practical Pointers for Providers.” The first couple of slides are the CMS disclaimers. So we can go through those, and certainly, Leah and Pat can touch on any other questions regarding those if there need be.

So I'm going to progress through the slides that you all have, progressing through to the disclaimers and then onto the agenda there. We're onto slide four and I'm going to start with “Transitioning to ICD-10: Practical Points for Providers.”

What we will have today is – transitioning, as we look at slide five, transitioning to ICD-10 practical pointers. Just an introduction, I work for the Spartanburg Regional Healthcare System, here in Spartanburg, South Carolina, and I'll do a little bit more background on our institution in just a few moments.

We have in slide six, “ICD-10: How am I supposed to get there from here?” We have multiple organizations involved in a transition from ICD-1 all the way through to ICD-10. Most recently, in ICD-10, we have this revision organizational structure and there are multiple people involved in that revision steering group. And so we identify a few of them here in slide six.

As we can see, multiple specialties have been involved in this. It wasn't just the group of administrators; they did try to involve physicians, leaders, and representations from each of the multispecialties.

In slide seven, we get to the idea of the transition timeline. As we all know, CMS has announced the delay from October 1st of 2013 to October 1st of 2014. So we're presented with that challenge – am I going to be able to get my institution, my providers, and to myself to ICD-10 on

time? The big, great answer to that is, yes. Yes, you can. And what we need to do is use this extra time that we have to make it even a better, smoother transition.

In slide eight, we have some examples of the ICD-10 transition timelines. Each of our organizations and our supporting bodies have come up with some version of a transition timeline, whether you look at the AAPC and AHIMA or into individual professional groups – the AAFP, the American Academy of Pediatrics, the AMA. CMS, of course, has created theirs with the basis of the ICD-10 structure and the World Health Organization with the basis of ICD-10.

So many people have those. What do we do with them? Well, who am I and how do I know that we're going to make it through this transition? I am currently a practicing family physician. I do what I call womb-to-tomb and everything in between. I am a faculty with the residency program. I practice fill full-spectrum family medicine, including delivering babies. I am a certified coder for both inpatient and outpatient medicine. And in that capacity, I work to teach our residents family medicine and coding. I also get to help our hospital system and our HIM folks in areas of coding and documentation, as well as physician advising. And most importantly, learn a lot from what they are doing on a day-to-day basis.

In slide 10, I work for the Spartanburg Regional Healthcare System. So who are we? We are a big hospital system in the upstate of South Carolina. We have two acute hospitals and a long-term care facility. We also have a regional hospice house, over 5,000 employees, and over 500 physicians.

In slide 11, we can see we have a large service area, a very busy ER, quite a few inpatient and outpatient surgical procedures going in, quite a few babies to be delivered, as well as both a chest pain and a stroke center and an active cancer community research area.

In slide 12, our outpatient group, because we are educating both inpatient and outpatient providers. We are part of a 16 family medicine and internal medicine practices, OB-GYN, pediatric and multispecialty groups, from surgery to cardiology, endocrine, rheumatology.

So slide 13, we are a large hospital organization. And when you're that big and that good, we are recognized and tracked by a lot of these governing bodies. We are closely watched by CMS and OIG, as many of you all are. We are under the auspices of Medicaid, Medicare, the RACs, the MACs, the MICs. All of these are things we need to be aware of and be cautious for.

So what is our readiness strategy? Well, being in South Carolina, we were one of the lucky ones, part of the initial RAC demonstration project in 2005 to 2008. And as we all know, in 2008, we were set up within the four regional contracts around the country. We are in Region C. When we initially had to prepare for the RAC audit, Spartanburg Regional set up three divisions within utilization management. We created our HMS discharge planners that are active on the floors and helping to get our patients smoothly transitioned out of the hospital.

We have case managers who will review all admissions for observation and inpatient compliance. And they have become a key part of our physician adviser group. And we have our documentation integrity team; this has worked with our CDI, clinical documentation improvement folks. They are the ones reviewing all of our active charts to make sure we are documenting our comorbidities, our complications, our principal diagnoses to make sure we're accurately capturing severity of illness and risk of mortality.

Initially, when we were dealing with the RAC audits, we contracted with our external physician adviser group for the observation and inpatient backup. We eventually, over the last two years, have transitioned to a completely in-house physician adviser group that is doing our RAC audits and is now starting to incorporate some of the MAC and MIC reviews.

So what happens with all of this? Well, we in the last two years have been hitting our docs with the RACs, the MACs, the MICs. And now we tell them, you've also got to prepare for ICD-10, but we have an extra year.

So how do we incorporate the physicians and our midlevel providers into this?

So moving to slide 17, we have what SRHS has done for its ICD-10 transition, how we prepared. We created an ICD-10 steering committee and an ICD-10 awareness and education committee. We have a project manager that coordinates our meetings. We have, within that, coordinated visits with our consultants and some of the different software and hardware folks that we use. They have come through, looked at our background, looked at our structure, given us some project timeline outlines. We have used our IT and our billing systems to look at our vendor readiness, look at our different payment systems, and look through each of the different computer aspects and applications to make sure that they would be ready when it came time to transition to the ICD-10 applications.

For our ICD-10 awareness and education committee, our basic structure, we realized – we had different levels of education from our HIM coders, who were going to be doing this on a daily basis, our CDI, BIT nurses, the folks who touch the chart in any way, shape, or form – patient access, physician office staff, and, of course, the physicians.

So slide 18. Educational sessions. As we prepare for ICD-10, educational sessions were structured from our HIM management and some of our in-house ICD-10 trainers. We created an in-house education system, recognizing, of course, the budgets that we all struggle with.

What we identified was four levels of educational need. Within our ICD-10 steering committee, we realized that there were going to be different levels based on how much of a contact these folks had with the ICD-10 codes, with the information they needed.

So you would have one level of education for folks dealing with admissions and scheduling; those on the floor, unit secretaries who are actively entering orders; those who are dealing with the day to day diagnoses and problems, such as our physicians, midlevel providers and nurses; all the way up to the highest level, those who were coding the chart of the information management, clinical documentation, and documentation integrity team.

So in slide 19, we created multidisciplinary teams, including office management and physicians that would attend the educational sessions. The ICD-10 trainers created webinars based on PowerPoint presentations that the office management who attended the core sessions could then take back to their offices and give to other folks within the office.

We structured the PowerPoint presentations for physicians in brief bullet points. We have a hospital intranet, and these webinars were stored on the hospital's intranet to be replayed over and over.

The initial education sessions are designed to introduce ICD-10 without being overwhelming, particularly with the delay from 2013 to 2014 and our initiation of this preparation back in 2011, 2012, we wanted to make providers actively aware of what was going on, but not hit them with too much, too soon. Again, you educate somebody on ICD-10 codes in 2011 – what's the likelihood that they will remember it in 2014 when you're alternating them with RAC, MAC, MIC and meaningful use?

So the next slide number 20. Our other opportunity was to reach out to the physicians and the midlevel providers on the side. With our CDI, and our DIT nurses, actively on the floors with the physicians and with the open charts, they have the opportunity to indirect directly with the providers. They are currently gathering the information on ICD-9, looking for the severity of illness and the risk of mortality. While they are reaching out and trying to get some of that information, they are able to give specific tidbits, specific insight that says, “OK. This is the current information on ICD-9. This is a little bit more of the detail we're going to need for ICD-10.”

Again, as we did with the webinars, it's small bits of information, bullets that can be very appropriate to the physician at that particular time. They can focus on some of the key diagnoses, some of the important issues that we're identifying right now, such as health care-acquired infections, the severity of illness, and the risk of mortality.

On the next slide, what they can do and what our ICD-10 education committee does, is reach out to the people on the floors, and in the charts, and in the offices at the time that they are actively working on a chart.

We have what we call the paper queries or the pink slips. And these are little notes stuck on a chart that can remind folks of some of the key pearls that we're looking for. We've created laminated cards and flyers that are left at the nurse's station, in the doctor's work areas, and in any of the break rooms, the doctor's lounges, that may be a key topic or a key learning pearl for that particular time.

We also have information and mailings that come from our chief medical officer or some of our medical directors, that may be a current button issue or a key issue on ICD-10 that we're trying to educate the doctors on, such as procedures for joint injections or identifying heart failures, acuities, chronic kidney disease stages versus acute kidney injuries. So, again, our HIM and our CDI folks can look at what are our key diagnoses and how can we put that in small bullets of information at the time the physicians need it.

In the next slide, the other thing that we have utilized is the work already done by so many others. We've touched on a lot of these organizations having transition timeline. The great thing about these organizations is that they have also come up with toolkits: the professional coding organizations, each of the medical specialties – they have created resources and toolkits that, in many cases, are very specific to the particular branch they are dealing with.

So the AAPC and AHIMA have created transition toolkits. CMS has the general equivalence mapping, as well as the information that physicians and all hospitals can download for ICD-9 current codes, ICD-10 current codes, in PDF format that allows searching and transitioning to compare a 9 to a 10 code; and, of course, the World Health Organization, with its standard of the background for transitioning all the way through to the ICD structure.

And in the next slide. So our transition. We've talked a little bit about how we have educated folks along the path, but how are we identifying these key portals that we need for that education? What we started with is, tracking the education and where it's coming from in that source.

So similar to all hospitals, the start is where the patient enters the system to the transition of them being admitted to the hospital. So the key is getting the information and getting the documentation from the beginning.

We have folks down in the ER who are educating our EMS on the new requirements for Glasgow Coma Staging, our ED nurses and our ED physicians to document detailed chief complaints to including past medical history, to making sure even as we have transitioned to a new ER documentation system, to make sure that the parts of that system are capturing the necessary information.

And within the EMRs that you all may use in your institution, you will find different elements and different bullets that may be, particularly, within the ER visit that captures meaningful use elements, that captures severity of illness, risk of mortality; and several of those bullets, particularly, in the system we use, can even capture data that can be used on some of the national guidelines and some different objective rating scales, such as TIMI scores and the San Francisco Syncope score, some of those that assist with second-order review, when you have folks coming through trying to capture detailed comorbidities, definitions for inpatient observation qualifiers.

So you can use that initial documentation and use your EMR to capture key elements. The next step of education is taking what the ER system is putting into that electronic medical record and making sure that you're admitting – and primary team is capturing that information and putting it into their admission H&P, and their daily progress notes, and, of course, the key that we all depend on, is that discharge summary.

Within the admitting and the primary teams, certainly one of the key points of education for ICD-9 and ICD-10 is helping them to understand the difference between that admitting diagnosis and those principal and secondary diagnoses on discharge.

We have, part of our ICD-10 education, HIM and utilization management folks working with that transition. We are looking to get both our admitting diagnoses on the H&Ps and the daily notes to document anything related to present on admission, document staging, document severity and, of course, progression throughout the hospital course.

And the next slide, 24. What we can do as a hospital system is identify your top diagnoses. Those coming out of the ER, those being admitted from surgery, those being admitted from private offices –what are the most important diagnoses that your institution deals with and to focus education at that point of care and at the place of service. Utilize our in-house resources.

We have expanded some of our personnel, as we have expanded our physician advisor in-house group. We have been able to have one of our utilization management nurses in the ED to assist with observation and classification – observation versus inpatient classification at time of admission. We can even start that process of having folks look at the documentation for diagnosis specificity at time of admission.

Now the next slide, 25. So outpatient versus inpatient, we touched a lot on what we've done for our inpatient, but how do we emphasize that same process for our outpatient providers? Most importantly, is helping the doctors to understand that, of course, on the outpatient side, we're going to be dealing with the ICD-10 CM code.

Thankfully, CPT is going to stay the same. Our doctors don't have to worry about the umpteen thousand ICD-10 PCS codes coming their way, but they do need to understand the CM codes. We are going to progress, as you all know, to over 70,000 ICD-10 CM codes. Doctors are going to need to identify and describe more specifically and more complexity.

In slide 26, outpatient providers, we're doing a similar process. Each of our offices by specialty can identify their top 20 outpatient diagnoses, their referral patterns, their diagnostic procedures. We can, again, structure focused education at the place of service. Many of our HIM educational sessions have gone in to individual physicians' offices to try to be convenient for them, get to a morning meeting, a lunchtime meeting, go out and introduce these webinars, introduce these bullets, so that they can get an overview of what we're doing with ICD-10.

We utilize the resources available in the office, who is already there that may have attended one of the sessions or have an understanding of ICD-10. Focused education is done based on the practice that we as physicians have had since med school, “See one, do one, teach one.” So what we can do is introduce the topic to the physician, to the midlevel providers, let them practice those ICD-10 codes, and then hopefully, teach one of their colleagues, teach the medical students, or teach a resident rotating through their office. Just like the ICD-10 train the trainer course: train a few, and have them teach each other.

Next slide. Transitioning from individual practices to the big system, and then the big system to the individual practices. Spartanburg Regional is a large health care system and then the regional physician group breaks it down into smaller individual offices. The key structure is it's a stepwise process, no matter what the size of your institution. Make use of your available resources.

And the next slide. We're all familiar with the PDSA cycle – Plan, Do, Study, Act. This is a basic structure. You plan ahead to what you have to do. You do it on a small basis. You tested the system. And you try it again. You learn what works and what didn't work until you’ve got it right.

So what are some of the strategies? In slide 29, we can see the planning part. You establish the structure and the budget, and you explain to everybody involved what is this transition, who will need to touch the chart, who will need to be prepared for the transition. And, of course, there are many resources that have already been outlined. Use the resources. Create your timeline and stick to it. Even with that extra year, this should not give us a reason to delay the project. This should give us more time to study and repeat.

So, in slide 30, the testing and transition, we need to involve everybody that is going to be impacted by the process to get their thoughts on, “how am I going to be impacted and, once it's tested on me, how do I respond and how can I make it better?” Monitor the impact on your claims and your reimbursements. Have a check-and-balance system to look for coding accuracy and productivity. Be prepared. Is this transition going to slow down your coders or speed up your coders? Is that going to, in turn, slow down your revenue cycle or is it going to improve your reimbursements? Be prepared to make changes and repeat the process.

So, in slide 31, what are some of the specific changes that are coming our way? You all have heard about the 5010 electronic format. One of the most important things from the physician

perspective is that we're going to increase the number of codes we're submitting. We have more space to describe the patient. We have to understand that the physicians can now outline more level of detail, but the physicians need to be willing to do that, indicate the complexity of service and the need for more services or higher level of office evaluation and management or procedures.

In slide 32, when you've got that many more codes to submit, it allows for that greater specificity that is now required for those meaningful use, for the national quality indicators, with so many offices now being NCQA-accredited or PCMH, the Patient-Centered Medical Home. These are all things that affect CMS reimbursement either now or soon in the future.

Some of the key pearls that we've been working on already [are] your diabetics, your hypertensives, your heart failures. Some of the other things we have looked at, just from a patient-care perspective, are the complications associated with those underlying medical problems. And some of the things that we've been able to generalize in the past in ICD-9, we see that we can start getting more specifics.

And, as CMS has adopted some of the transition from 9 to 10, how are we doing in our health care maintenance, in our screenings? How does that all tie in to a Patient-Centered Medical Home? These are things that can now be documented with the higher number of codes that we have with ICD-10.

So, some specific examples in this transition, ICD-9 and ICD-10 comparison, the common ones that doctors need to be aware of – we now have dual diagnosis coding for diabetes, one of the most common things that we have to code for, and accurately coding a diabetic patient, just that one problem can have 10 to 12, easily, diagnoses on their active problem list. In ICD-10 we have the advantage of diabetes with the complication all being linked into one code. We don't state in ICD-10 so much controlled, uncontrolled on their chronic problem list, but we have the option on that particular day's note that a single code that classifies their underlying condition and their manifestation with the staging such as diabetes type 2 with nephropathy or diabetes type 2 with chronic kidney disease.

And then, if their glucose is uncontrolled on that particular day, we can add in the code for diabetes with hyperglycemia; but again, it’s the option physicians need to classify and they need to clarify those complications related to one of the most common diseases and all of this

information can be captured within our patients and our medical home meaningful use NTQA indicators.

Some more examples as we have listed on 34, ICD-10 offers us the opportunity to be more specific. Right now one of the things that complicate physician documentation and coding is when you are trying to code for a procedure, a joint injection, or some type of therapeutic, be it a bracing, a splinting, an intramuscular injection for pain. In many cases, in ICD-9, we have pain in limb, where I may be treating their right leg and their left leg with two different therapies. I can't currently clarify which limb I'm doing and it might look like I am duplicating the treatment and trying to have a higher level of acuity or complexity on my office visits by duplicating services on one limb.

In ICD-10 with physician education and helping them to understand the specificity, I can make it very clear to my payer that I am providing a service on the right side, the left side, the knee, the arm, the leg, individual parts of the limb. So ICD-10 allows us to that extra information.

In slide 35 as we can see, ICD-10 offers a specificity, but we've got to get the physicians to use it. Without physician education and buy-in, what was garbage in before is going to be garbage out now. But one of the greatest things is that you can all be taught. We as physicians came out of medical school with a degree, but we have a lot more to learn, and yes, we can be taught the new system.

So slide 36, focus on the good, reassure the physicians some things are not going to change; CPT is CPT. Some of the codes have more detail; but, in general, if they're trying to learn the new book, the structure is still the same, most of the chapters follow in the same pattern. Help physicians by creating the long list and the short list of commonly used codes. Thankfully each specialty comes out with those on an annual basis. Utilize resources that are already available: cms.gov has excellent resources with the general equivalence mapping, downloads for physicians and for coders.

Utilize the resources that we've already had, look for specialty specific codes, and educate specialists on their small area.

And then slide 37, look for the online system. Patients now have access to all the different systems to rate us and to compare and contrast us. Make sure that our physicians know where they're being rated and how they're being graded.

Help the physicians to see that what they're trying to do is take care of their sickest patients, to provide the best quality care, not just to meet national standards, but most importantly, to do what we all went into medicine for, and that's patient care. But if we're going to take care of our truly sickest patients, then let's get credit for it.

And the best thing is we focus on the good. Sooner or later we all reach the point where the light at the end of the tunnel is not just the oncoming train but smooth, sweet success. The doctors can be educated.

And on that, we list a couple of resources for Spartanburg Regional and some of the information for the World Health Organization. And at this point, as I finish up, before we transition to the next speaker, I will turn it back over to Leah and Holly for a brief opportunity for some polling.

Leah Nguyen: Thank you, Dr. Boyle.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results.

Holly, we're ready to start polling.

Polling

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person on the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between two and eight, if there nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between two and eight, if there nine or more of you in the room, enter nine. Please hold while we complete the polling.

And please continue to hold while we complete the polling. Thank you for your participation in the polling session. I'll turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holly.

Our next presenter is Pat Brooks from the Hospital and Ambulatory Policy Group of the Center for Medicare, who'll be covering general ICD-10 requirements and CMS implementation planning.

Pat Brooks: Thank you, Leah.

I want to thank Dr. Boyle for providing this excellent insight on how providers can help physicians to get ready for ICD-10. She gave some very practical suggestions.

I'm going to add just a few important implementation issues that some of them are repetition, but others are issues that I want you to be aware of. Beginning with slide 41, once again, the new implementation date for ICD-10 is October 1st, 2014. That's for both the ICD-10 CM, the diagnoses and ICD-10 PCS, the procedures.

For those of you who want to read about the announcement about this delay and to see the final rule, we do provide links to those in the middle of slide 41. We've also provided an MLN Matters article at the bottom of slide 41, which gives you, updated ICD-10 implementation information. This includes the new implementation date, the benefits of ICD-10, differences between ICD-9 and ICD-10 in the code structure and information of the general equivalent mapping that help you map between ICD-9 and ICD-10 codes.

Moving on to slide 42, we'll state once again that ICD-10 CM, the diagnosis part, will be used by all providers in every health care setting. So every provider that reports diagnosis codes now will need to learn to use ICD-10 CM diagnosis codes.

ICD-10 PCS, the procedures, will only be used for hospital claims, for inpatient hospital procedures. ICD-10 PCS will not be used on physician claims, even for those physician claims for inpatient services.

Slide 43 mentions what Dr. Boyle has told you previously: there'll be no impact on HCPCS or CPT reporting. And they will continue to be used.

Moving on to slide 44, let me stress that we have a single implementation date for October 1st, 2014 for all users for ICD-10. This implementation date is the date of service for ambulatory physician reporting. In other words, physicians who treat patients beginning on or after October 1st, 2014 will report ICD-10 CM diagnosis codes for those services.

For hospitals, the implementation date is based on the discharge date. So for inpatient discharges occurring on or after October 1st, 2014, you will use ICD-10 CM and ICD-10 PCS.

On slide 44, we provide information for one large conversion project that we've done within CMS, and that's converting the inpatient prospective payment system from ICD-9 to ICD-10. We refer to that as the ICD-10 MS-DRG conversion project. And for those of you who want more details about that and how we went about it, where we are in that process, you can click on this Web page to get information.

One announcement I'd like to make is that we will be posting version 30, which is the current version of the MS-DRG. We will be posting the ICD-10 version of the MS-DRG within November 2012. We will also be making available a mainframe and PC version of version 30 of the ICD-10 MS-DRG software from NTIS in early 2013.

I know a number of people who have been anxiously awaiting those and so we're pleased to make that available.

Now, let me stress that the final version of the ICD-10 MS-DRG will be subject to formal rulemaking. We've simply been sharing all these annual updates to ~~generally~~ get input from providers on how well we are converting the current MS-DRGs to ICD-10. And we appreciate the comments we continue to receive on that.

Moving on to slide 46, those of you who want to know about the annual updates to codes for ICD-10 CM and ICD-10 PCS, we post those each year on our ICD-10 Web site. And when you get to that Web site, if you look on the left side of the page, you'll see the current and the past year updates for ICD-10 CM and ICD-10 PCS.

For those of you who are interested in how updates are made to ICD-9 CM and ICD-10 codes, we do that through the ICD-9 CM coordination and maintenance committee, and that meets twice a year. For detailed information on that committee, we've provided a link where you can get additional information.

On slide 47, the good news for many of you who are struggling or worrying about moving to ICD-10. In the past, we had many updates to codes each year, sometimes, in the hundreds, and these large code updates were extremely disruptive.

This created problems for schools that are developing educational material providers teaching ~~positions~~ physicians, those working on the super bills that are trying to come up with the most common codes. The good news is that we're in a partial code freeze now.

And on slide 47, we show that the last regular annual update to both ICD-9 CM and ICD-10 was made on October 1st, 2011. For this past October 2012 and next October 2013, there will be only limited code updates to capture only new technology and new diseases.

October 1st, 2014, the date of ICD-10 implementation, there will be only limited code updates to the ICD-10 Code 6 to capture new technology and new diseases.

On slide 48, we showed there will be no updates to ICD-9 CM on October 1st, 2014, as a system will no longer be a HIPAA standard. In other words, ICD-9 CM will not be used to capture services provided on or after October 1st, 2014.

On October 1st, 2015, one year after the implementation, regular updates to ICD-10 will begin. For those of you who want to read more about the partial code freeze update or you want some educational material to share within your organization, the bottom of slide 48 puts a MLN article that summarizes the partial code freeze.

For slides 49 to 52, we are simply providing additional reference material for you to look at later, in case you have more questions about ICD-10. Slide 49 is the general ICD-10 Web site, and you can see – you can sign up for e-mail updates, Twitter, latest news.

We also provide a Web site for 5010. On slide 50, we, once again, mention the ICD-10 Web site and provide a link to calls such as the one we're having today, that's ICD-10 teleconferences.

I would urge you, if this is your first call, to look at those prior calls that are equally valid now to learn more details about additional ICD-10 implementation areas. And there's a particularly good call among these posted for ICD-10 CM basics that you'll probably find extremely useful. We provide both the transcripts, audio recordings, and the slide presentation.

Slide 51 gives you some links to good resources and fact sheets that will be helpful to you. And slide 52 gives some organizations outside of CMS that provide excellent resources through the industry, where people can list products or services that are ICD-10-related.

Leah, that's the end of my presentation. Thank you.

Leah Nguyen: Thank you, Pat.

Our next presenter is Janet Anderson Brock from the coverage and analysis group of the Center for Clinical Standards and Quality with an update on National Coverage Determination and ICD-10.

Janet Anderson Brock: Good afternoon. I am Janet Anderson Brock and I'm coming to you to discuss our progress on the translation of our edits and related policy information that we put out in transmittal from the past where it's concerning the national coverage process.

So, I am going to do a little context setting because I think there is some delineation that needs to be understood right off the bat.

The first thing I would like to say is that transition is a process. And we've been talking about transition. And translation, especially policy translation, is just a mere activity or step within that overall process.

So, that's what we've been focusing on. But you'll understand as I walk through this how this relates to many other pieces, such as the connection to the payment system, which I am sure we are all interested in.

So, I am going to take you first to slide 54, and there are two types of coverage that we confer here in Medicare, and they are local and national coverage.

Local coverage determinations are determinations made by an individual MAC or FI or carrier, for its legacy contractors, that cover a jurisdiction. So, they are very limited in scope. These determinations, as I said, are jurisdictionally based, with the exception of DME. For our DME contractors, they collaborate on the policy, and the policy is identical across the country.

If you'd like to think of it as a factor of the national coverage, you may, because that's how we think of it. Each individual MAC will be responsible for doing their own code translations, and that's because there is local variation. And we have encouraged the CMBs to talk to one another. We've built a tool on the backend of our local coverage determination database that allows them to see the translations that are occurring in a counterpart jurisdiction so that they can gain the wisdom of their CMB counterparts in other areas.

And we believe that this is going to help that transition process happen smoothly. But it is occurring at the local contractor and not at the CMS central office.

Now, the other type of coverage is national coverage, and that's what is being translated out of my shop. Now, national coverage spans decades of historical decisions. And some of them, as time has evolved, have become more specific and more precise. Some of the ones before 1999 were neither of those things, to be honest.

So, we've had to take a very concerted look at our history in total and decide what our guiding principles were going to be when you talk about translation. So, we came up with a few guiding principles.

The first – and this is very big – is that not all NCDs can be translated from ICD-9 to ICD-10. Now, that might sound like a show-stopper. But if you think about some of our older national coverage policies, especially those that were about noncoverage, we don't do as many of those these days. But those that were about noncoverage really focused on the procedure, not so much the diagnosis.

So the edits that were in place in all of those things centered around the device or the drug or the DME and not really about the diagnosis.

So, that makes it so much easier to handle especially when we are talking about translation.

And then, the other thing, our guiding principle, probably our primary guiding principle if you want to prioritize them, is that we in no way want coverage to change in the midst of doing a translation.

So, in order to preserve the coverage that we have on September 30, 2014 and have the exact same coverage on October 2nd, 2014, what we've done is go through a pretty integrated process. And I am going to explain that in a minute.

So, what I wanted to reiterate is national coverage determinations are national – it’s in the title. And that our coding hasn't always been national, but we are getting to a place now where the edits in place are unified edits.

We put out information through our transmittals that explains what Medicare does pay for and doesn't pay for with respect to codes. And that information does not get modified by subsequent

local policies. There is a national policy in place. There cannot be a local policy that comes through and modifies that in any way. Where there is no national policy in place, a local policy can dictate the coverage for that item or service.

While we have 330 NCDs, I'm here to tell you that approximately only 40 percent of them will be translated. I am not going to tell you the exact number because we keep changing it every day.

But it's about 40 percent. And the reason for that, as I suggested, the ones before 1999 had some rather indistinct language in them, or we just say that we out and out don't cover something and it's based on the procedure.

So, we found that order obsolete. The interesting thing about the coverage process is, in order to retire something or take it off the rolls, we actually have to open it up first, put it out for public comment, and go through the entire process, which is very resource-intensive in order to take it off the rolls. The only exception to that is for our lab policies.

We've also determined – so outside of that 40 percent – that most of our DME policies that are at the national level are not suitable for translation. There are a few exceptions. I am not going to say 100 percent of our DME policies will not be translated. But many of them will not.

And this is because we have DME contractors who collaborate. And so, we have ways to make sure that coverage is unified across this nation for our Medicare beneficiaries. That does not include going through the rigorous process of doing shared systems edits and those types of things.

So, we feel comfortable that, because of the extreme collaboration that happens with our DMACs, that we've got a good alternative to shared system edits for DME.

So, as I mentioned, we're in the process of reviewing all of our NCDs. And we've been trying in, maybe not a 100 percent coordinated way – if I am going to get to how we're getting coordinated, this is a learning process, to give that information out as we make these translations.

Initially, when we would write a new national coverage policy – and I am talking about in the last two years – we would put out a transmittal that would explain the coverage for ICD-9 and then we would also explain what the translation will look like for ICD-10.

Now, we didn't put an effective date on that ICD-10 translation. But it is there in the transmittal.

And those transmittals are easy to find if they are topic-specific, because they start with the title ICD-10. And it will say ICD-10 or ICD-10 screening for alcohol misuse. And so, they are easy to identify if you are looking for them. If you're not looking for them, you wouldn't know they're there.

So, we've taken a second approach because, of course, not everything is new. We have a history, as I mentioned. So, how do we translate those historical documents, those NCD policies that still live and breathe and are important for payment?

We've looked at them. We found our 40 percent that we feel are suitable for translation and we've been doing what I like to consider omnibus transmittal. So, it's a release – we call them change requests. But you are familiar with them as a transmittal.

We do a release that gives you a translation for many NCDs. And those NCDs don't necessarily have to relate to one another in any way. They are just the ones that, for that release, were ready to go through and be displayed to the public. The way that we got through the translation process is this, because I think it's important for you to understand the steps that we've taken.

We have enlisted the help of others, starting with some subcontractors that have been very important to us. One of them was 3M and the other was WPS. WPS is a MAC. And what they bring to the table is their coding experience and their local flavor as they process our claims. So, that's extraordinary helpful.

3M, of course, the creator of the CPT tool and knows an awful lot about the ICD-10. So, they bring a lot to the table as well.

So, what we've done is we have taken our ICD-9 policy – we've taken the policy as it translates in ICD-9, double-checked it to make sure that there were no changes from the time that we originally picked those ICD-9 codes, made it appropriate, and then looked at the CPT translation to see what the ICD-10 translation would look like. But we didn't stop there, because there is a lot of medical subtext to some of these translations, and it's so important to make sure that we're getting an equivalent translation that will still create the same payment at the end of the day.

So, once we had that process, we took it and we handed it off to our medical officers and also to a consensus body, which consisted of a medical director in each of the MAC jurisdictions, who

was very nice and volunteered their time to go through this, because they found the importance of this to warrant that kind of investment.

So, they went through and they said, “Yes. You know what? We agree with the translation,” or “We think you missed a code here or we think this code is inappropriate.”

We wanted that process to happen so that we can make sure that we didn't put anything in our shared systems, as far as an edit that would preclude payment that wasn't there before. We always know that things can be tightened up in a jurisdiction and that individual local coverage, if there was contractor discretion, would take care of some of things that you are used to seeing in your jurisdiction. But we didn't want to do that across the United States, because that wasn't our mission here.

After we did the consensus building with our medical director, we then did a validation check to make sure that we were comfortable with any changes that were made. And only then did we release it to our systems maintainer. So, here we're talking about a fourth level of review who said, “You know what? This isn't going to break the system,” or “This is exactly what we had in the system before in the sense of – as the claim come through, it's going to pay the same way or they told us when it wouldn't.” And we made sure that we worked through those.

At the same time, we also looked at things like frequency to make sure that everything was true to the stated national policy that's in our NCD manual and what's in our claims processing manual. So, this was a very long step, but an important step for us.

And only then were we ready to show it to the public. So, that's how we got through the entire CR process. And I am pleased to say that we've already released our first omnibus CR, change request, and that the MLN Matters article that is referred to on slide 56 points you to that transmittal.

You can get there and what you'll see might be a little daunting, so I am going to tell you that right off the bat.. But you get an idea of the requirements that we put in place. And those are pretty basic. It's replace these ICD-9 codes with this ICD-10 codes. That's easy.

Then, you get – for this one actually – 36 spreadsheets of codes. And what we tried to do to make it as user friendly as possible is, we've labeled each one of those spreadsheets as a separate file. So, you get them as sort of an attachment.

Those separate files are titled by the NCD number. So if it were artificial hearts, I think that's 20.6. I might have that number wrong, but we named it by the title of the NCD and the NCD number. And you opened it up, and you get one file for Part A, and you get one file for Part B.

So we hope you can go right to where you want to go to find the information that you need, and you'll see the translation. We show what it was for ICD-9; we show you what the translation is for ICD-10.

At the same time, we also have information in there about the frequency edits; so you can see that it is unchanged and any of the messaging that was important for our contractors especially but may be instructive to others. Providers may care about this—the messaging as well.

We are going to do two more of these omnibus CRs—these omnibus transmittals. You'll see one very soon in April. We will have an MLN Matters article when that one comes out. The transmittal number to look for is 8109.

And then we will have our final translation CR transmittal in July of this year. At that point, all new translations will occur through individual topic-specific transmittals, as I suggested we were doing previously. We will continue to do that; we don't want a backlog of stuff that we need to translate. And we will take a second look at the translations that we've made right prior to ICD-10 going live to make sure if any new codes creep in during that partial freeze ~~[and]~~ that we've updated the translations that we've made to make sure that everything is ready come October 1st, 2014.

And with that, I am going to turn it back over to Leah.

Leah Nguyen: Thank you, Janet. Our final presenter is Chris Stahlecker from the Administrative Simplification Group of the Office of eHealth Standards and Services with an update of ICD-10 and administrative simplification.

Chris Stahlecker: Thank you, Leah. I am really pleased to be here today, and I just wanted to draw a little bit of a differentiation between some of the prior presentations and this presentation because I am speaking from the, as we have indicated, Office of eHealth Standards and Services. That is the area that actually develops the regulations.

And so we did need to publish this date after it was decided in April of this year to make a modification, and I wanted to cover a little bit of the rationale of why the date changed.

So, I'll slide right over to slide number 58 in our presentation.

It was September 5th that we published the final rule, and you've heard many times today it's been changed to October 1st of 2014.

I wanted to go over some of the rationale why that date was selected and why it changed at all.

For industry watchers, the signs were there, although not from any one group or single issue that led to a decision to delay or change the date, but rather, there was a series of events and issues that occurred that the industry clearly was signaling that they needed more time. One of the first signs was our version 5010 implementation.

I have to note that if you're not on version 5010, there's no way that you're going to be able to implement ICD-10. 5010 was the precursor project. And while it’s just changing a format for the electronic transaction—it was considered a pretty easy transition, much easier than ICD-10—there are lessons learned or lessons to be learned from that implementation.

First, there were some errata with the transaction standards, even though that the corrections may have been simple and not affected everyone—some typographical errors or certain data content. Those changes did affect the vendor readiness, and that was like a domino effect. The vendors were delayed in delivering their products. They were backlogged there, and then the installations were backlogged. Billers that needed those new versions of software were prevented from extensive testing.

Additional difficulties occurred when some payers front-ended systems and edits. There was some linkage with submitters and providers that did not or was not recognized until the transition to production. It did not. It was a problem that perhaps didn’t exist in the testing environment because, if there were some changes, they were only recognized once a move to production occurred.

So with the system, even though these are all standards, they're all subject to interpretation, and that adds another layer of complexity. Overall, CMS listens to industry feedback regarding some of the reasons for looking for a delay. Providers were experiencing potential or true delays in payments or nonpayments.

We considered that situation looking forward and realize the potential for providers not meeting payroll or shutting down operations and then the trickle-down negative effects on patients’

access to care. And that was essentially the primary reasons for considering a delay in the ICD-10 implementation.

Providers weren't the only ones, though. Once we did an extensive outreach, other industry segments offered some of their concerns. They admitted that after the delay was announced, there's a consideration of the delay, that their members could truly benefit from some additional time.

So then the question became how long? And we don't want you to think that we just picked a year delay. We heard a lot of comments from industries. Some were saying don't move it from October 1st, 2013; some were saying go out to 2015. Some were looking for ICD-11. Essentially, when we balanced the books, and we looked at all of the comments, we believed that the 1-year delay timeframe balanced the overall needs.

That additional year will give the small provider practices and other entities some additional time and doesn't significantly penalize those entities that have already invested heavily with considerable time and effort based on their initial understanding of the October 2013 date.

And we'll move to slide 59. One of the key comments, however—and I'll point back to the NCDHS hearings in June of this year—was that a trend was in the comments. It said, "Please do not have an extensive implementation coincidental with ICD-10."

So on our slide 59, we're showing you what administrative simplification regulatory dates, compliance dates are coming up on the horizon. We got January 1st, 2013, with our eligibility claim status operating rules. Followed closely, December 31st, the same year, health plans must certify that they are compliant with eligibility claim status and EFT and ERA standards associated with the operating rules.

Then you'll see that the next date on our chart here points to January 1st, 2014, and you're going to be saying, "Why are these dates seemingly flip-flopped? How can you say that you're attesting to being compliant with the standard before it's actually effective?"

And I wanted to point out, right at the get-go here, that this discrepancy will be addressed shortly. But just see right in the center of this slide that ICD-10 does stand alone—October 1st, 2014. We'll follow it up with the November 5th, 2014, where health plans, the large ones, must

have obtained their health plan identifier, and note that small plans have an additional year. It's just getting yourselves—the health plans—getting themselves enumerated.

Then on December 31st, 2015, our additional operating rules; hopefully, then January 1st, 2016, will be attesting to being compliant. The final date that we have here is November 7th, 2016, where the health plan identifier will actually begin to be used in the transactions. Not begin to be used, let me correct myself.

All of the transactions must be using health plan identifiers, and only the health plan identifier, where that piece of data is being communicated. So there's a whole suite of activities that I'm going to talk about toward the end of this presentation about how we're going to support all of these things by emphasizing that the October 1st, 2014, date is not expected to be changed again.

Moving on to slide number 60. How does ICD-10 integrate with the overall EDI? Well, the connection among CMS is eHealth Initiatives. It's unmistakable. Interoperability, and that's one of the end games here. Interoperability requires the use of uniform health information standard such as ICD-10, along with SNOMED.

They work together as structured documentation to demonstrate meaningful use and make sure that the administrative transactions reflect the appropriate clinical event. So you have SNOMED the clinical standard and ICD-10 as the administrative transaction. They need to align to make sure that the information that's being conveyed is actually the appropriate information.

So how is interoperability, including the monitoring and enforcing of Electronic Health Information Exchange Standards, an essential component of the National Health Information structure? Interoperability at the national level benefits clinicians with having a longitudinal medical record with full information about each patient.

Consumers also have improved access to management and management capability for their own health status through their personal health records and access strategies, such as mobile health applications via smartphones and touchscreen tablets. Consumers can also move more easily across the health care settings without concern that their information has been lost. Payers can benefit from the economic efficiencies, fewer errors, and reduced duplication in the reimbursement process.

The interoperability is the foundation for public health reporting, bioterrorism surveillance, quality monitoring, advances in clinical trials, and health care policy decisions. The rest of the globe is already on ICD-10. The United States is catching up.

When it comes to ICD-10 for that matter, all of the HIPAA standards, medical code sets, identifiers, and operating rules—we first need to consider how they integrate and contribute to this health care endgame, including their contributions for health care quality.

The first recognition of this integration was the inclusion of ICD-10 in the EHR certification criteria and the recent Meaningful Use Stage 2 Regulations. And going forward, you will hear more about—more conversations about this intersection of data, quality, standards, and the other eHealth Initiatives.

Moving to slide 61, so what has CMS been doing with their implementation of ICD-10? And I'll just point out that the Office of eHealth Standards and Services has oversight responsibility here within CMS for implementing ICD-10. And since the delay was initially signaled in April, CMS has continued with its ICD-10 implementation. We continued to push ahead with internal implementation efforts, but of course, like everybody else, some of our work has been slowed down waiting for the compliance date to be announced.

Our ICD-10 Steering Committee continues to meet every other week and hash out some of the dependencies and the timetables in progress towards the October 1st, 2014, implementation. We estimate overall that we're approximately 50 percent complete. That's not to say that 50 percent is all of the work. There are some areas that are totally completed, while other areas have to wait for preceding dependencies to be completed before they can be fully closed out.

Our industry outreach is going to be stepped up to concentrate on some practical tools aimed at reaching small providers and hospitals. And our goal is to have preparations for as many of our systems and business processes as possible completed by October of 2013 so that we can devote the remaining year to testing.

And that's to segue to another important area, slide 62—our ICD-10 testing and compliance. One of the other very valuable lessons learned from version 5010 is that, despite all of our standards, operating rules identifiers, when it comes down to our own industry, we are still lacking a common understanding of what we are articulating.

What do we mean with end-to-end testing? What do we mean with compliance? What do we mean with readiness?

When the survey with the industry was—when the industry was surveyed as to their readiness for version ICD-10, the responses were typically very positive and that only served later on to learn that we are all working off of our own individual interpretations and concepts of what we meant by readiness. That same applies to end-to-end testing and compliance: what do these terms actually mean?

More importantly, how does our industry gain enough confidence to say that we are ready for the ICD-10 cutover date? They are very crucial conversations and questions that will have to occur; that will determine how we operationalize ICD-10 as well as the other HIPAA standards. Based on this 5010 experience, we cannot assume agreement or understanding of the answers.

Each question begs some discussion and consensus across CMS and across all industry segments. We know that there are many industry groups already working on the testing question, and we intend to have an active role on those efforts. We're willing to tee up these discussions and believe potential consideration given to the national committee on vital and health statistics and the FACA Committee that's responsible there for making recommendations to the Secretary could be an appropriate venue to make this happen.

And we're also proactively working on a pilot to develop a protocol so that standards that the Secretary is considering for adoption are pretested before they are recommended for implementation across the industry. We also have another pilot that I'm going to speak about to explore end-to-end testing, questions, and implications. So let me move on to slide number 63.

What is our roadmap to interoperability? Again, referring back to the recommendations heard at the NCDHS hearings in June of this year, the industry was clearly requesting CMS to provide guidance. One specific request is for a roadmap that is understandable and reflects prioritized deliverables.

The roadmap needs to clearly indicate the activities per milestone and the timeline. We'll be taking some of the content, the regulations identified in that "what's coming" slide in my presentation earlier, and recommending an appropriate set of activities based on industry collaboration.

This isn't CMS just defining them. We have a contractor under way now to help us with an end-to-end definition of pilot testing, and these activities will be presented, along with the timelines that complement those activities, with results from our end-to-end pilot test. It will also include our HIPAA next, or our 6020 pilot that I referred to you on our prior slide, and we expect to have a very cohesive and comprehensive communication program addressing the FY 2013 activities. So I can say more to come, and we hope to be speaking with you soon about some of those deliverables.

And with that, Leah, I'm still free to answer questions.

Leah Nguyen: Thank you, Chris. Our subject-matter expert will now take your questions about ICD-10. Before we begin, I would like to remind everyone. This call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one.

All right, Holly, we are ready to take our first question.

Question-and-Answer Session

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity, and please note, your line will remain open during the time that you're asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Samuel Raj.

Samuel Raj: Hi. This is Samuel from Glenwood. I have a question about the ICD-10 and SNOMED for the electronic medical records we are using. Because so far, for the problem lists we are maintaining with our ICD-9 codes, and now when we migrate to ICD-10 for meaningful use, they call for SNOMED codes. So there is no one-to-one mapping between those tools. So how do I—how am I going to maintain two sets of codes for every plan? Our problem is entering time going to have.

Chris Stahlecker: All right. It's Chris Stahlecker here. That's really a question that should be answered by our electronic and health initiative team. We can take that question back. I do

believe you're going to need to make your best attempt at looking at those SNOMED codes, and the software certification criteria for presenters that are preparing those systems have now included the capability of ICD-10.

So ICD-10 is an option, but you do—you must implement SNOMED codes. So that will take significant – maybe not significant—but it will take some doing on your part. We can take this question back though and try to get you more wholesome answers. There may be some best practices about how to go about that so we can take that in.

Samuel Raj: Thank you.

Chris Stahlecker: I think you have an e-mail address. Leah is going to give you now.

Leah Nguyen: Yes. We have an e-mail address listed on slide ~~26~~ 66. It's icd10-national-calls@cms.hhs.gov. Thank you.

Samuel Raj: Thanks.

Operator: Your next question comes from the line of Donna Shaw.

Donna Shaw: Hello. Has there been any information that maybe CMS has received from payers that may not be converting to ICD-10? And I'm probably specifically referring to workman's comp in some States.

Chris Stahlecker: This is Chris Stahlecker. I don't believe that we've received that feedback at this point. We haven't issued a survey in some time, and we do want to issue a survey. And so we do note some have like, you know, are expressing concerns, but we do believe that the improved communication education and outreach program that we will be putting forward will give the industry some general assistance in tooling up their delivery schedules, so – but your point, being point-blank, well, the – OK, but I've forgotten the term you said for the claim types you're talking about.

Donna Shaw: Like the workman's comp I was referring to.

Chris Stahlecker: We haven't heard of that in particular, but we can look into that, and if you want to send in an e-mail to the address that Leah just mentioned, we can get to a direct response.

Donna Shaw: Great. I appreciate that.

Leah, can you provide that e-mail again, or will it be posted?

Leah Nguyen: Oh, sure, it's actually on slide 66. It's ICD-10…

Donna Shaw: OK, great.

Leah Nguyen: OK.

Donna Shaw: Yes, great. Thanks.

Chris Stahlecker: And of course, these questions will give us some interesting opportunities to post frequently asked questions. So we're anxious to take the next one.

Operator: Your next question comes from the line of Ular Williams.

Ular Williams: Yes, will there be a presentation for DME providers in transition of the ICD-10?

Pat Brooks: This is Pat Brooks. So we haven't decided on what our next presentation would be. I don't know that we have focused particularly on DME providers. We try to keep these pretty generic on all kind of providers—the ICD-10 issues. But thank you for making that recommendation.

Ular Williams: Thank you.

Pat Brooks: Thank you.

Operator: Your next question comes from the line of Kevin Baron.

Kevin Baron: Hi. I had a question regarding – we're a very small hospital here in Chicago, and I was just wondering what your recommendation was as far as implementing a CDI program along with the ICD-10 implementation. Currently, we don't have a CDI program, and I know it's something that our hospital has been talking about. But you know, in meeting with other vendors, they – you know, I just want to know what other hospitals are doing.

Leah Nguyen: Why don't we have Dr. Boyle give her feedback from an actual person working in a hospital—what she thinks about that?

Kevin Baron: OK.

Ginger Boyle: Now, again, is this how your particular institution can connect your CDI program to ICD-10? Is that what you are referring to?

Kevin Baron: Well, yes, pretty much. I want to know what the standard in industry is, because we don't have a CDI program here at our hospital. And some of the vendors with the ICD-10 implementation want to do both at the same time, and we're a little apprehensive about rolling both programs out at once. So maybe if you guys have any suggestions or what, you know, other standard industry people are doing as far as about having the CDI program—is it better to roll both of them into one or to do the implementation of ICD-10 and then wait on the CDI?

Ginger Boyle: Do you have a structure in your institution at this point that helps to capture information, like from the inpatient documentation or the active open chart? What are you doing right now to try to tease out information for severity of illness and risk of mortality?

Kevin Baron: You know, we have our director of HIM, and their department currently does that now but not at the level of a CDI program.

Ginger Boyle: OK. So are they doing it on closed charts, or do the HIM folks … ?

Kevin Baron: Closed charts, yes.

Ginger Boyle: OK. So I would say that probably one of the easiest —one of the simplest stepwise—starts is, I would, while you're still working on ICD-9, is try to see what you have within your institution, and if you have the available resources, to have somebody start the CDI, because I think you can start the CDI and have people looking at the active charts on 9 and get that up and rolling now.

With, again, some of the resources that CMS, AHIMA, and the CDI governing agencies or collective groups have to help—critically, nurses or documentation specialists within HIM. There are resources within the CDI networks to help those people transition from 9 to 10. And so I would propose that the short and simple—running them parallel—whether you utilize an outside vendor to run them parallel, or I would look within your own institution and see who in your HIM department may be interested in moving from that closed chart investigation to an open chart investigation and see if you may have within your institution people who would like to venture into the CDI world.

Kevin Baron: Right. OK.

Ginger Boyle: But you may not need the vendor to incorporate both ICD-10 and CDI in your institution at the same time if, within your network, you may have a CDI resource already built in.

Kevin Baron: OK, thank you very much.

Ginger Boyle: Yes.

Operator: Your next question comes from the line of Faith McNicholas.

Faith McNicholas: Hi. This is Faith McNicholas from the American Academy of Dermatology. I wanted to ask CMS staff about whether there has been any consideration from transitioning from ICD-9 directly to ICD-11 and what—if there's any discussion going on. Thank you.

Chris Stahlecker: Hi. It's Chris Stahlecker. Yes, we did have a look at that, quite frankly. But the ICD-10—I'm sorry, the ICD-11—codes are not available yet. And if we look at how long it took for the ICD-10 codes to be developed, we could not even envision ICD-11 codes available for several years. And quite frankly, you know, we just can't continue to exist on the ICD-9 codes, that we cannot advance our health care delivery system based off of code values that are becoming obsolete and very complicated to convey any meaningful information. It's causing a lot of additional documentation to be required, and so we just can't stay on the 9 codes. So we don't really have an option here.

Faith McNicholas: Thank you.

Operator: Your next question comes from the line of Trina Ewing.

Trina Ewing: Trina Ewing, with Memphis Gastroenterology Group. We're a GI practice, and I noticed on slide 32 you mentioned 12 codes for specificity for meaningful use. I was wondering if you could just elaborate more on that slide 32?

Ginger Boyle: What I'm implying on that is the number of diagnoses that physicians can include when they are coding an individual office visit. Right now, on the 1500 form, you're limited to those four diagnoses. And as we expand, some of the other documentation and claim submission forms, be it 5010 or whatever comes down in the future—that physicians will be able to or

claims will be able to include more than just four codes, and physicians will be able to better elaborate and better utilize the multiple codes in ICD-10 to describe how fixed their patient is.

Trina Ewing: OK. So with regard to the health care maintenance screenings, for example, the colonoscopy, are you just saying that we will be able to provide more specific diagnosis codes, like the screening as well as any health risk factors?

Ginger Boyle: Yes.

Trina Ewing: OK.

Janet Anderson Brock: This is Janet in the coverage and analysis group. I think it's important for the screenings, especially for all of those of you who do provide preventive services, to remember that, for screening, we don't really base it on diagnoses. Those, you know, that that's really the diagnostic services that we provided that are related. For example, we have a screening mammo; we have a diagnostic mammo.

For screening, by and large, those are procedure-based. So—and frequency edits are employed, depending on the technology, but it's not usually diagnosis-based unless we're talking about a high-risk/low-risk split, and that's usually right out of statute.

Trina Ewing: OK. OK. That makes sense. That's what was confusing, because I know currently we'd submit G codes for the screening colonoscopy, so I didn't really understand how the 12 new diagnosis codes would affect those procedures.

Leah Nguyen: Thank you.

And, Holly, how many participants do we currently have in the queue?

Operator: Apparently, we have 11 participants in queue.

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

Operator: Your final question comes from the line of Rachel Cotler.

Rachel Cotler: Hi. I work for Liberator Medical Supply. We supply durable medical equipment. My question is, will the DME providers have to obtain a new prescription so the patients are receiving supplies on or after October 1st, 2014?

Right now, our prescriptions have the ICD-9 code on them when we bill for the services that we provide. Are we going to have to replace the thousands of prescriptions we have on file?

Pat Brooks: This is Pat Brooks. I don't totally understand your question, because I don't work in that area. All I can tell you is that if you report ICD-9 CM diagnoses codes now, you will have to replace that those with ICD-10 CM diagnosis codes beginning with services on or after October 1st, 2014—if that addresses your question.

Rachel Cotler: OK. So can I just ask one more thing in regard to your answer? You know, to be proactive—I mean, we have literally thousands of patients that we service. And if we try to get prescriptions early—you know, a couple of months in advance to try to keep up with it to make sure there's no lapse in supplies for our patients that are using catheters and, you know, different durable medical equipment—are we going to be able to bill with the new codes before October 1st?

Pat Brooks: The answer is, once again, it's a hard-and-fast rule that you cannot report ICD-10 codes for services provided before October 1st, 2014.

Rachel Cotler: I see.

Pat Brooks: And you must pre-plot, supply the 10 codes for services provided on or after October 1st, 2014.

Rachel Cotler: OK, thank you very much.

Pat Brooks: Thank you.

Additional Information

Leah Nguyen: Unfortunately, that's all the time we have for questions, and we apologize that we did not have more time for questions today. If we did not get to your question, you can e-mail it to icd-10-national-calls@cms.hhs.gov. The address is also listed on slide 66. 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, the American Health Information Management Association, and the American Medical Billing Association for participation in CMS National Provider Calls. Please see slide 65 for more details.

I would like to thank everyone for participating in the Preparing Physicians for ICD-10 Implementation National Provider Call. On slide 67 of the presentation, you'll find information in a URL to evaluate your experience with today's calls. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls resource box within 2 business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note: evaluations will be available for completion for 5 business days from the date of today's call. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS Fee-For-Service National Provider Calls Web page. Again, my name is Leah Nguyen, and it has been my pleasure serving as your moderator today. I would also like to thank our presenters, Dr. Ginger Boyle, Pat Brooks, Janet Anderson Brock, and Chris Stahlecker.

Have a great day, everyone.

Operator: Thank you for your participation. You may now disconnect.

END