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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
More ICD-10 Coding Basics
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Operator: At this time I would like to welcome everyone to today's MLN Connects 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, you may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on More ICD-10 Coding Basics. MLN Connects Calls are part of the Medicare Learning Network.

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. Providers will have an extra year to prepare. During this MLN Connects Call, join us for a keynote presentation on ICD-10 coding basics by Sue Bowman from the American Health Information Management Association, or AHIMA, along with updates from CMS. A question-and-answer session will follow the presentation.

You should have received a link to the slide presentation for today's call in previous registration emails. If you have not already done so, please download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select the June 4 call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

And last, please be aware that continuing education credits may be awarded by professional organizations for participation in MLN Connects Calls. Questions concerning continuing education credits should be directed to your organization.

At this time I will turn the call over to Pat Brooks from the Hospital and Ambulatory Policy Group of the Center for Medicare for CMS code updates.

Presentation

Pat Brooks: Thank you, Leah. If everyone would turn to slide 6, we'll review a statement released by CMS on the ICD-10 compliance date.

"On April 1, 2014, the Protecting Access to Medicare Act of 2014 was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require – require the use

of ICD-10 beginning October 1, 2015. The rule will also require HIPAA-covered entities to continue to use ICD-9-CM through September 30, 2015."

And on this slide, we have a link for those of you who want to watch for the release of any interim final rule. This link will take you to a place where you can find it posted.

If you will turn to slide 7, we'll discuss the partial code freeze. We instituted a partial code freeze to reduce the burden on providers and payers when they were having to deal with a large number of annual code updates while preparing for ICD-10. With this partial code freeze – we plan to continue it until 1 year after ICD-10 is implemented – we are only creating codes for new diagnoses and new technologies.

The last regular update to ICD-9 and to ICD-10 was on October 1, 2011, and in that year, we had around 150 new ICD-9 codes and about 465 new ICD-10-CM diagnosis codes. Since that time, we've got – only had a handful of code updates because of the partial code freeze. The regular ICD-10 updates will begin once again on October 1, 2016, or 1 year after the implementation of ICD-10.

Moving on to slide 8, you will see that there are no updates planned for October 1, 2014. And that means there will be no ICD-9-CM code updates. And we've provided a link on the slide to find the annual list of ICD-9-CM codes. There also will be no ICD-10-CM or ICD-10-PCS code updates, and we have a link to the ICD-10 website where you can see the annual code updates.

This will be the first time since the Coordination and Maintenance Committee was established to update codes that we have had no code updates on October 1st. And once again, in recent years, there have been as few as one and, basically, just a handful of code updates with the partial code freeze.

Moving on to slide 9, for those of you who are interested in requesting a code update, that is addressed by the ICD-10 Coordination and Maintenance Committee. This committee does address updates to ICD-10. The requests are due 2 months prior to any meeting, and the next Coordination and Maintenance Committee meeting will be September 23rd through the 24th, 2014. So clearly, you need to have any requests for that meeting in 2 months prior to the meeting. Once again, we're only considering new diagnosis and new technology codes because we're under the partial code freeze.

And requests for new diagnosis codes ICD-10-CM should go to Donna Pickett at CDC. And on slide 9, we provided her email address. Requests for procedure codes ICD-10-PCS should go to me, Pat Brooks. And I've provided my email address on slide 9.

Moving on to slide 10, we will just discuss the ICD-10 MS-DRGs. We've had an ongoing project over the last few years to replicate the MS-DRGs that are now based on ICD-9-CM codes. Currently, the version that we are using in hospitals is version 31. And we have replicated that with an ICD-10 MS-DRG version 31.

Resources

We have posted on our website a definitions manual, and we're also making available to the public mainframe and PC software for the MS-DRG and the Medicare Code Editor. And that's being made available through the National Technical Information Center – Service – NTIS. And we also provided a link on slide 10 where you can get this information on the ICD-10 MS-DRG.

Slides 11 through 13 discuss a lot of really good resources that you should, after this call, look through if you haven't already. Slide 11, one of the important ones, is the ICD-10 website. And for those of you who want to know when a rule is issued or what's going on with code updates or whatever, I would encourage you to sign up for the CMS ICD-10 industry email updates. And then you will hear from us quickly about things that happen.

The second bullet gives you links to ICD-10 teleconferences like the one today. And if you missed some of the prior ones, you can find posted audio and slides for prior teleconferences that are equally valuable to you. We have provider resources – fact sheets, and other information on our website.

On slide 12, you'll see a number of types of things that are available, such as testing resources, articles, videos. And at the bottom of slide 12, you'll see that we've given a link to the National Coverage Determination Conversion Information for those of you who are interested in how those are progressing and how they are using ICD-10 codes.

And slide 13 is two organizations that are providing valuable resources to the industry – WEDI and HIMSS. And if you're just looking for products or vendors or various kinds of resources, you can go to these websites and get additional information.

Thank you, Leah.

Keypad Polling

Leah Nguyen: Thank you, Pat. 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'll be a few moments of silence while we tabulate the results.

Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone 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 in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. 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. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Thank you. I would now like to turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Victoria.

At this time, I would like to introduce our keynote speaker, Sue Bowman, Senior Director of Coding Policy and Compliance from AHIMA.

Presentation Continued

The Benefits of ICD-10-CM

Sue Bowman: Thank you, Leah. We are now on slide 15. Before I get started going through some of the features and conventions and components of ICD-10-CM, it's important, I think, to understand some of the key benefits of moving to this new coding system. Some of those benefits include that ICD-10-CM is much more clinically relevant than ICD-9-CM. It better reflects clinical severity and complexity. It's a more accurate representation of providers' performance.

The code choices are a lot less ambiguous than what we experience with ICD-9 today. Because of the greater detail in ICD-10, we can better represent medical necessity of services. Physicians and other providers can help to validate their evaluation and management codes because of the specificity in the new diagnosis codes. And there's more accurate and fair reimbursement, again because the codes are a more clear and accurate depiction of the patient's condition.

And ICD-10 codes permit the documentation to be translated into a much more accurate and clear clinical picture, thereby reducing the chances of misinterpretation by third parties, auditors, and attorneys and other third parties. One way to think of ICD-10 is as a tool for providers to use to be able to represent the severity or complexity of an individual patient's conditions to payers and others or the severity or complexity of their patient population to auditors and even consumers.

Now moving on to slide 16, it also provides some improved efficiencies and lowered administrative costs. And you might wonder how that can be when we hear about – so much about the expense of moving to ICD-10. Well, because of the clearer information and greater specificity that the codes provide, we anticipate that there will be fewer rejected and improper reimbursement claims, as well as a decreased demand for submission of medical record documentation. Today a lot of payers request a followup documentation because the ICD-9 codes really don't give them enough information about the patient encounter.

Because of the increased specificity, the ICD-10 system also allows for better automation of tools to help facilitate the coding process. We have electronic tools to help with ICD-9 coding today. But these tools could be even better with ICD-10, when there is less ambiguity and more clarity with the code description itself. The increased specificity can

also mean fewer coding errors, again because of the decreased ambiguity as well as increased productivity, because it's a bit easier to see which code is the correct code.

Sometimes today with the ICD-9 ambiguous nature of the code descriptions, we all spend a lot of time scratching our heads trying to figure out which one of the vague ICD-9 codes is the best choice for a particular clinical scenario, so increased specificity help with that. And all of that, ultimately, leads to reduced labor costs. So using a contemporary classification system that's designed to keep up with 21st century medicine will do a lot to hopefully reduce the administrative burden that we currently experience with a lot of coding and billing requirements today.

Comparing the ICD-9-CM and ICD-10-CM

Now moving to slide 17, let's compare the ICD-9-CM and ICD-10-CM structure. ICD-9 has three to five characters, whereas ICD-10-CM has three to seven. The first character in ICD-10-CM is an alpha character, and all the letters, except the letter U, are used. The second character is numeric. And characters three through seven can be alpha or numeric. So the codes are quite a mix of alpha and numeric characters. There is a decimal point after three characters, which is the same as we see in ICD-9 today.

And it's important to keep in mind because we get this question a lot – the alpha characters are not case sensitive. So while presentations or codebooks or other resources might reflect the alpha character is an uppercase letter, it really doesn't matter as far as the systems are concerned because the letters don't have different meanings if they're in upper or lower case. So, if it's – if you enter a lowercase "a" or an uppercase "A," it has the same meaning in the code assignment.

On slide 18. There's a lot of similarities to ICD-9-CM and ICD-10-CM. The tabular list is structured very similarly. There's a chronological list of codes divided into chapters based on the body system with condition. The system has the same hierarchical structure that we're familiar with today in ICD-9. And the chapters are structured very similarly to ICD-9, with a few minor exceptions. There are a few chapters that have restructured. And, for example, the sense organs – eye and ear – have been separated into their own distinct chapters.

On slide 19, the alphabetic index is also very similar in both ICD-9 and ICD-10. It's an alphabetical list of terms and their corresponding codes. There are indented subterms that appear under the main term. It has the same structured content with an alphabetic index of diseases and injuries, an alphabetic index of external causes, table of neoplasms, and table of drugs and chemicals. So when you look at ICD-10-CM, you will see a lot of these elements are very similar.

On slide 20, a lot of the conventions and rules within ICD-9-CM you will also see again in ICD-10-CM. It uses a lot of the same abbreviations, punctuations, symbols, and notes such as "code first" and "use additional code." There are still unspecified or not otherwise specified codes available for use when the documentation does not support a more specific code. And the process of looking up the code is the same. You start by

looking up the clinical term in the alphabetic index and then verifying the correct code within the tabular list by looking at the instructional notes in the tabular list to see if any of those would direct you away from that particular code. And we're going to be walking through some coding examples a little bit later to show you how that process works.

On slide 21, codes are invalid if they're missing an applicable character, which is a concept in both ICD-9-CM and ICD-10-CM. And both have a set of official coding guidelines for use with the coding system. And adherence to these coding guidelines is required under HIPAA.

On slide 22, now we're going to talk about some differences within ICD-10-CM as compared to ICD-9-CM because, obviously, if there weren't any differences, we wouldn't be going to the trouble of making the switch. Well, the biggest one is really the expanded detail and specificity within ICD-10 to reflect the changes in our healthcare environment and the direction we're going with – with more demands for data. The codes reflect modern medicine and updated medical terminology. And even though, initially, ICD-10-CM was developed some time ago, it has been maintained and updated over the years, showing that its structure is much more flexible than ICD-9-CM and able to keep up with changes in modern medicine. Laterality has been added to relevant codes. And there's quite a bit of expanded use of combination codes, such as conditions and their associated symptoms or manifestations or poisonings and their associated external cause.

And it's important to keep in mind when you look at the different chapters of ICD-10-CM, is that this system was developed with significant public input, including a lot of clinician groups because information has been added that was felt to be clinically relevant or better needed to assess quality of care, distinguish levels of severity, and evaluate patient outcomes – all areas of information that the U.S. and other countries are increasingly demanding of healthcare data compared to when ICD-9 was developed and was primarily just used for indexing of diseases so that you could pull all of the records with a particular disease, which is why the codes are somewhat ambiguous. But in today's world, we expect a lot more of our healthcare data than we did at that time.

On slide 23 there are some examples of some of the combination codes such as atherosclerotic heart disease of native coronary artery without angina; age-related osteoporosis with current pathological fracture, vertebrae, initial encounter for fracture; type 1 diabetes with diabetic chronic kidney disease; and acute cystitis with hematuria. So you can see both the level of detail within the code and also some of the types of combinations of associated conditions that were merged into a single code in ICD-10.

The ICD-10 Seventh Character

On slide 24 we're going to talk about a new feature within ICD-10-CM that is not in ICD-9, and that is the use of a seventh character, which is not throughout the whole classification, it's just within certain chapters – OB, injury, musculoskeletal, and external cause chapters. And it has a different meaning, depending on the section where it is being used. So, the seventh character isn't used in exactly the same way in all of the chapters where it appears. It must always be in the seventh character position. And when the

seventh character applies to a particular code, any code missing a seventh character is considered invalid.

So here's some examples on slide 25 of how the seventh character is used in different chapters. In the obstetric chapter, it's used in multiple gestation codes to identify the specific fetus affected by the condition. So when there is a condition that might affect one fetus but not the others, then there is a seventh character so you can identify which fetus has been affected. In the injury chapter, the seventh characters identify type of encounter, which we're going to be talking about a little bit more later, closed versus open fracture, routine versus delayed healing, and malunion or nonunion of fracture.

On slide 26, in the musculoskeletal chapter, the seventh character is used to identify some of the same things as in the injury chapter – type of encounter: routine versus delayed healing, malunion and nonunion, and also some additional clinical information has been incorporated into the – some of the seventh characters. In the external cause chapter, the type of encounter is captured in the seventh character.

So let's talk about the seventh character describing the different types of encounter. And we're now on slide 27. An initial encounter is used as long as the patient is receiving active treatment for the condition. In a subsequent encounter, it's used after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

And these seventh characters have created some confusion because the term "initial" and "subsequent" seems to imply that you would only use the initial encounter seventh character once for the very first encounter. But, that's not how they're to be applied. And we're going to walk through some examples that show that.

But as long as the patient is still receiving active treatment, even in multiple encounters, you would still use the seventh character for initial encounter. And one way to think of it, for those of you who are pretty familiar with ICD-9, in ICD-9, we have aftercare V codes that are used for followup visits and for home healthcare and physical therapy and those kinds of things. So if you think of the subsequent encounter as the scenarios where you would have used the aftercare V codes in an ICD-9 world, that's one way to look at it.

Another area of confusion has been that some people have thought that the subsequent encounter referred to a repeat incident of the same injury. And it does not. It's referring to the same injury as the initial encounter but at the point where the patient is now just receiving routine care and has completed the active treatment phase for that injury and it's just healing and being followed up or receiving therapy and so forth.

The sequela seventh character is the late effect seventh character for conditions that arise as a direct result of the condition and are usually some sort of long-term effect – for example, a scar following a burn, for example. And when using the sequela seventh character, you add the sequela seventh character to the injury code and then also add a code for the specific type of sequela that the patient experienced, such as the scar code.

We're going to – at least walk through some of these seventh characters a little bit later so you can see how they are applied.

Examples Using ICD-10 Seventh Character

So, here is an example of some of the seventh characters used in the fracture section of the ICD-10-CM codes. And we're now on slide 28. So we have seventh characters for initial encounter for closed fracture, initial encounter for open fracture, subsequent encounter for fracture with routine healing, subsequent encounter for fracture with delayed healing, and subsequent encounter for fracture with nonunion, subsequent encounter for fracture with malunion, and then, sequela.

On slide 29 I show some examples of the use of the seventh character, and the underlined portion of each code is the part of the code descriptor that relates to the seventh character. So the first one is an OB example showing the identification of the specific fetus – maternal care for breech presentation in fetus two.

And then, the second one is from the Musculoskeletal chapter. And this is an example of where the seventh character is being used to describe some additional clinical information. So it's idiopathic chronic gout, left knee, without tophus. And there is another seventh character, of course, that would be with tophus.

The next one is an example of a fracture code with displaced fracture of the shaft of the left clavicle. Subsequent encounter for fracture with delayed healing is the portion of that code that is identified in the seventh character.

And then, the final code is from the External Cause chapter – a passenger on a bus injured in a collision with a car, pickup truck, or a van in a traffic accident, initial encounter.

On slide 30, another new feature in ICD-10-CM is the use of the placeholder X. And addition of this dummy placeholder is used in certain codes to allow for future expansion of those code sections. And it's also used to fill out empty characters when a code contains fewer than six characters and a seventh character applies.

And that might sound a little confusing, but we'll show some examples later where a code – the base code might be fewer than six characters but it has a seventh character that applies and, therefore, you – since we said earlier the seventh character must always be in the seventh character position, then you use the dummy placeholder X to fill in the extra positions. And when the placeholder character applies, it must be used in order for the code to be valid. I've noticed that some codebook publishers have really tried to help people out by displaying the placeholder X in the codes – in the codebook that require them so you don't forget to include the placeholder in the reported code, which is a helpful feature.

On slide 31 again, just like the other alpha characters within the ICD-10-CM code, the placeholder X is not case sensitive. So while you may often see it represented as either uppercase or lowercase, it really doesn't matter which way it is entered.

Another feature in ICD-10, as shown on slide 32, is the division of excludes notes into Excludes1 and Excludes2 notes. And this is a really helpful feature in ICD-10. An Excludes1 note indicates that the code identified in the note and the code where the note appears cannot be reported together because the two conditions cannot occur together. So, for example, in this diabetes case for a diabetes code, there is an Excludes1 note for other types of diabetes because, for example, you couldn't have Type 1 and Type 2 Diabetes together. You could – you would have one or the other. So, this would be an example of an Excludes1 note where you could not assign both of those codes together.

On slide 33, an Excludes2 note indicates that the condition identified in the note is not part of the condition represented by the code where the note appears. So both codes may be reported together if the patient has both conditions. And so, in this pressure ulcer category, there is Excludes2 note for other types of ulcers. So it's trying to tell you that if you have a pressure ulcer and a diabetic ulcer, the pressure ulcer code does not include the diabetic ulcer code or other types of skin infections. You would need to code that separately.

So this distinction between the Excludes1 and the Excludes2 notes is a really helpful feature because in ICD-9-CM we don't have this distinction, and that's led to a lot of confusion and coding questions about the meaning of some excludes notes as to whether you can use the codes together or not because they have both meanings in ICD-9, it's just that you don't know which it is. So this is a really helpful distinction to be able to identify when codes can be used together and when they can't.

On slide 34, I did want to mention that there are still unspecified codes in ICD-10-CM. When sufficient clinical information isn't known or available about a particular condition to assign a more specific code, it's still acceptable to report the appropriate unspecified code. And obviously one of the big benefits of ICD-10 is the greater detail and specificity, and certainly we want to encourage good documentation that supports the most specific codes as possible. But sometimes, even in the best of circumstances, it's not always possible to have the documentation or even the clinical knowledge about a condition to support a more specific code. And so it's very appropriate to assign an unspecified code in those cases. It would not be appropriate to select a specific code that's not supported by the medical record documentation or to conduct medically unnecessary testing just to get to a more specific code. You basically – you code what you know.

In addition to unspecified codes, ICD-10-CM, just like ICD-9-CM, also has default codes for some conditions, which are indicated by index entries or inclusion terms under the codes that basically tell you that in cases where it might not be identified more specifically, that you would use the more common version of the code in that particular situation.

External Cause Reporting

On slide 35 we're going to talk about external causes of morbidity, which I know has created a lot of controversy within the ICD-10-CM codes. Just as with ICD-9-CM codes, in ICD-10-CM, there is no national requirement for mandatory ICD-10 external cause reporting. Reporting the ICD-10 codes in Chapter 20 of ICD-10, External Causes of Morbidity, is only required if there is a state-based external cause code reporting mandate or a particular payer happens to require those codes. In the absence of a mandatory reporting requirement, providers are certainly encouraged to voluntarily report these codes.

And it's important to note that, over the years, the number of states requiring external cause code reporting has grown because of the additional valuable information they provide about how and where the injury occurred. But that's really completely unrelated to the transition of ICD – to ICD-10 and has been going on long before we started the process of moving to ICD-10.

So why is external cause information useful? We're now on slide 36. Well these codes provide valuable data for injury research and evaluation of injury prevention strategies. They are used at the national, state, and local levels to identify high-risk populations, set priorities, and plan and evaluate injury prevention programs and policies and are potentially useful for evaluating emergency medical services and trauma care systems.

Improving the availability of an access to high-quality coded data regarding external causes can benefit auto insurance companies, disability insurers, health insurers, public payers, healthcare purchasers, employers, businesses, labor unions, schools, and other entities interested in injury prevention and safety issues.

Coding Examples

Now let's walk through a few coding examples, starting on slide 37.

By the way, I'd like to mention that if you haven't already purchased a copy of an ICD-10-CM codebook, have it in an encoding system, or some other type of electronic tool, you can get an electronic copy of ICD-10-CM from the CMS and CDC websites for free. And codebooks are also widely available for ICD-10-CM in both paper and electronic form from a variety of vendors at very economical prices. So I did want to make that point.

So on slide 37, let's walk through an example of cerebral infarction due to thrombosis of left middle cerebral artery. Well, you start by looking the term up in the alphabetic index, the main term of infarction, cerebral. And it does have "see also occlusion, artery, cerebral or precerebral, with infarction" note there. And, then, underneath – so, you could look at that and see if it had any additional terms. But under this particular term of cerebral infarction, it does say "due to thrombosis, cerebral artery, I63.3."

If you had looked up the see also reference, you would have already – you would have even gotten an index entry down to middle. But even if you don't do that, when you go to the tabular, you can hone in to the middle cerebral artery code.

So on slide 38, you look I63 up in the tabular list and go to the I63.3, cerebral infarction due to thrombosis of cerebral arteries, and then look down to I63.31, which is middle cerebral artery and then, I63.312, which is cerebral infarction due to thrombosis of left middle cerebral artery. So that's the full code assignment.

It's important to know that you shouldn't code directly or – and can't really code directly from the index because a lot of times the index will only take you up to a certain point, and then you need to go to the tabular to find the rest of the characters for that code. Or you may get to the code and see an instructional note that relates to an associated condition that you – that has a combination version of the diagnosis you're looking for or gives you some other instruction that relates to the clinical scenario you're trying to code. So it's always important to go to the tabular and confirm the full correct code that you are seeking. Plus, for the chapters that use seventh characters, that's where you're going to find the application seventh characters as well.

So on slide 39, here is an example if all you know is stroke or CVA. And you look up accidents, cerebrovascular, and it gives you I63.9. And then, on slide 40, you verify that I63.9 is cerebral infarction, unspecified, and it even has an inclusion term of stroke NOS. So very clearly, that is the correct code for this scenario.

On slide 41, that's the patient with moderate persistent asthma with acute exacerbation. So you look up asthma in the index, and then scroll down to the subterm of moderate persistent. And then you see another subterm with exacerbation. Acute is a nonessential modifier – terms that are in parenthesis after an index term, it just means that the term may or may not be in the code description but it doesn't affect the code assignment. So whether it just said moderate persistent asthma with exacerbation or moderate persistent asthma with acute exacerbation, it would go to the same code. So then you look up J45.41 in the tabular on slide 42 and will see – you will see that J45.41, moderate persistent asthma with acute exacerbation is the correct code.

So you will notice that the process of coding is very similar to ICD-9. The specific code number you end up with is different, but the process of getting to the code is very much the same.

On slide 43, it's a case of bilateral chronic serous otitis media. So you look up otitis media, chronic, serous. And it says to see otitis, media, nonsuppurative, chronic, serous. So then you look that term up as I show on slide 44, otitis, nonsuppurative, chronic, serous, H65.2.

And on slide 45, you look at H65.2, chronic serous otitis media, H65.32 – I mean – excuse me – 23 – H65.23, chronic serous otitis media, bilateral is the correct code for this diagnosis. And I don't show it on this slide, but there is a note under H65 that you can

use an additional code from H72 for any associated perforated tympanic membrane for this code.

Now in slide 46, let's try an OB example. We have moderate pre-eclampsia at 23 weeks. So you look up, in this case, pregnancy, complicated by pre-eclampsia, moderate, O14.0. And then you look it up in the tabular on slide 47, pre-eclampsia, O14.0, mild to moderate pre-eclampsia and O14.02 is mild to moderate pre-eclampsia second trimester.

At the beginning of the chapter in ICD-10-CM, it explains that for these trimester-specific codes, the second trimester is assigned as 14 weeks, 0 days to less than 28 weeks, 0 days. So because this is 23 weeks, it falls into the second trimester code.

On slide 48, we have a diagnosis of pathological fracture of right tibia due to bone metastasis, previously treated, currently presents with nonunion. So you look up fracture, pathological, due to neoplastic disease. And then there is a subterm for tibia, M84.56. And then in the tabular, you look up M84.5, which is pathologic fracture in neoplastic disease. And on this slide – on slide 49 – I'm showing you the appropriate seventh characters that apply to this category because we're going to need to know them in just a second. Also note the note that says, "Code also underlying neoplasm" because we're going to need to pay attention to that in a second, too.

And then on slide 50, you verify the code in the tabular, M84.56, pathologic fracture in neoplastic disease, tibia, and fibula. And then .561 is the pathologic fracture in neoplastic disease, right tibia. Now remember, I said don't forget we need the seven characters for this particular code. So, if you look back on slide 49 and see what the character choices are, you know that this patient has nonunion and has previously been treated. So, it's a subsequent encounter for fracture with nonunion. So it would be a K for the seventh character.

Now on slide 51, remember I mentioned the notes under M84.5 that said you should also code the underlying neoplasm because the M84 code captured the pathologic fracture in neoplastic disease part but not the neoplasm itself part. So if you – if you know the primary and it still exists, you would code that or you would code the personal history of the primary. But we don't know that right here. We do know that patient has bone metastasis.

So on slide 51, we look at metastasis, spread to, see neoplasm, secondary, by site. So then you look up neoplasm, bone, tibia, secondary, and get a code of C79.51. And then, on slide 52, you verify that code in the tabular as a secondary malignant neoplasm of bone.

On slide 53 we have a diabetic case, Type 1 Diabetes with ketoacidosis. So, you look the term up in the alphabetic index, diabetes, type 1, with ketoacidosis, E10.10. And then, on slide 54, you verify that the code is E10.10, Type 1 Diabetes with ketoacidosis without coma because there was no mention of any coma.

On slide 55, here is a postop complication scenario, postoperative hematoma following cardiac catheterization. You look up hematoma, postoperative. It says, “See complication, post-procedural, hemorrhage.” So on slide 56, you look up that cross reference of complication, post procedural, hemorrhage, circulatory system or organ or structure following a cardiac catheterization, see I97.610.

And then on slide 57, you verify that code assignment of post procedural hemorrhage and hematoma of a circulatory system organ or structure following a cardiac catheterization. So you can also see the specificity within ICD-10-CM of the information it’s giving you, not just about the complication itself but even about the type of procedure that it relates to.

On slide 58, here we have a burglary suspect who presented to the ED with a concussion after being struck on the head by a blunt object by a police officer during a chase, unconscious for 45 minutes. So you look the term up in the index of concussion. We’ll start with the injury code here first, S06.0. Then, you go to the tabular. You will see we’re going to need to apply seventh characters to this code. There are also some instructional notes in this section of the code indicating that any associated open wound of head or any skull fracture would be separately coded, that’s not included in the concussion code.

On slide 60 we see S06.0x2, concussion with loss of consciousness of 31 minutes to 59 minutes, because remember in the scenario it said 45 minutes was the length of time he was unconscious. So the code assignment would be S06.0x2A. So remember, I mentioned that it showed seventh characters apply to this codes, and this is the initial encounter because this is still, obviously, part of the active treatment for this injury.

Then on slide 61, let’s look at assigning the external cause code. Remember, this is optional unless you’re under a state or payer mandate for external cause reporting or your organization has chosen to optionally report these codes. But for the purpose of this illustrative example, we’re going to go ahead and assign the external cause code. Plus I think you’ll find it interesting to see the level of specificity that this will provide.

So there is a separate External Cause Index. So you look up struck by law enforcement agent with blunt object. It says, “See legal, intervention, blunt object.” Then on slide 62, you look up legal, intervention, blunt object, just like the see reference sent you to – the cross reference in the previous slide. And there is a subentry of injuring suspect. There are other categories of innocent bystander and so on and the law enforcement personnel and other people who are injured, but in this case, it was the suspect. And we see a code of Y35.303.

So then on slide 63you look up Y35.303 and you will see legal intervention involving unspecified blunt object with the suspect being injured. I didn’t show the seventh character options on the slide, again for this particular code. But it does have seventh characters for the type of encounter, meaning initial, subsequent or sequela that are

shown in the classification. And so this would be a seventh character A for initial encounter because again, it is still part of the active treatment.

On slide 64 is a scenario of patient presenting to ED for bimalleolar fracture of the right ankle after falling down an escalator. So look the term up in the alphabetic index. It's a traumatic fracture, ankle, bimalleolar. It sends you to S82.84.

On slide 65 I show the S82 category, and I want you to pay particular attention to the notes under this category. There are notes there that say, "A fracture not indicated as displaced or nondisplaced should be coded to displaced," and "A fracture not indicated as open or closed should be coded to closed." And then this category also has seventh characters that apply.

So then you go down to the subentry for S82.841. And so you code it as a displaced bimalleolar fracture of the right lower leg. Displaced – this is an example of a default. The description of the scenario did not say whether the fracture was displaced or not. But according to the instructional notes in the classification, if it's not specified, you code it as displaced. So that's why we're picking the displaced code.

And the seventh character would be A because this is an initial encounter for a closed fracture. Again, it doesn't say that the fracture was closed. But per the instructional notes, it says that you would code it as closed if it's not specified otherwise.

And we'll code the external cause code, again for this scenario. It involved fall down an escalator. W10.0 is shown on slide 67. Then when you verify it on slide 68, it's W10.0xxA for fall on or from escalator. And this is an example of the use of the placeholder Xs. The code is W10.0, but you need to apply a seventh character for the type of encounter and so you need the placeholder Xs.

And as I mentioned earlier, a lot of the codebook publishers are beginning to show the placeholder Xs within the codes like I've shown here on the slide so that people don't forget to add them. And again, it's a seventh character A because this is active treatment for the fracture; it's not aftercare or followup.

So let's consider some other scenarios with the previous patient with the bimalleolar fracture that – after falling down the escalator. So say that the ED physician referred that patient to the orthopedist for evaluation of injury and definitive treatment and then that orthopedist scheduled the patient for surgery. And I'm now on slide 69. The same code assignment of initial encounter for the seventh character would apply for the emergency department, orthopedist, and surgical encounter visits because for all of those encounters, it's still active treatment. So you would still use the initial encounter seventh character.

On slide 70, say that same patient with bimalleolar fracture had received treatment, had surgery, was done with all that, is now going to physical therapy. In this case, the physical therapy encounter would use the seventh character for subsequent encounter

because this is now followup aftercare treatment or care during the routine or healing phase. It's no longer part of active treatment.

Say that same patient moves away and scheduled followup care with an orthopedist located in his new geographic area. Then that would still be a seventh character for a subsequent encounter. Although followup care is being provided by a different or new physician, it's still followup care and not active treatment for the injury. So I hope that helps to provide clarification regarding the use of the seventh characters because I know they have been somewhat confusing to people.

The Importance of Documentation in The ICD-10 Coding Process

So in our final minutes of the presentation, let's just focus a little bit on the impact and importance of documentation in the ICD-10 coding process.

High-quality documentation is, obviously, critical. Although it's not just being driven by the ICD-10 transition, improved documentation is being driven by lots of other initiatives, such as quality reporting, value-based purchasing, patient safety initiatives. But it's also important for achieving the best quality ICD-10 codes as well. And better clinical documentation promotes better patient care and more accurate capture of acuity, severity, and risk of mortality for things such as quality and performance reporting, reimbursement, severity information, risk adjustment profiles, provider performance, present on admission reporting, and hospital-acquired conditions.

If complete information isn't captured in the clinical documentation, the result is incomplete documentation for coding the impacts, revenues through delays, irrecoverable costs, missed revenues, and outcome measure that do not reflect the quality and complexity of the care delivered. So it's really, really important to achieve good quality documentation.

So on slide 72, some of the challenges to achieving good clinical documentation include ensuring high-quality documentation without excessive administrative burden or levels of frustration or encroaching on time spent on patient care, ensuring sufficient documentation to support coding without – while allowing providers do document in clinical, and not coding, terms. And I think that's very important that we capture that. And we need good clinical documentation, not a greater volume of documentation.

So on slide 73, to make the most of clinical documentation improvement efforts, identify opportunities that could impact multiple initiatives, not just on documentation solely for ICD-10. The idea is if we have good documentation, it will be there for ICD-10, Meaningful Use, anything else we need the documentation for.

Determine the best solution for addressing identified documentation gap. The same solution may not fit every scenario. So consider approaches such as modifications to forms or templates, EHR documentation templates, system prompts, additional education, or workflow or operational process changes. And don't try to change everything at once.

Prioritize clinical documentation improvement efforts by starting with the low-hanging fruit or the issues with the greatest impact.

And on slide 74, identify and implement changes in documentation capture processes such as the use of EHR documentation templates and prompts that I just mentioned that would facilitate improvements in clinical documentation practice up front so we can capture quality information at the point of care. I think sometimes we spend too much time at the back end running around, trying to get documentation after the fact, which is frustrating to both physicians and coders. So I think capturing it up front in the easiest way possible is the solution we should be striving for.

And better documentation has benefits today. It doesn't just wait for ICD-10 – reduced physician queries, better ICD-9 and CPT coding and support for all of the other healthcare initiatives that rely on high-quality clinical documentation. Use of electronic tools such as computer-assisted coding technology, as well as EHR templates and prompts, can facilitate coding and documentation processes by increasing productivity and accuracy, improving clinical documentation at the point of care, and reducing cost and claims rejections.

So on slide 75, here are some of the benefits of EHR documentation prompts. And I'm not going to read all of them to you. You can see those. But I think that it really is the best way to get documentation up front as painlessly as possible and it helps to overcome that language barrier between physicians and coders, some of which, I think, is being bridged just by moving to ICD-10 because there's very huge gap between the clinical terminology in ICD-9 and clinician documentation and, fortunately, much less of a gap between ICD-10 terminology and physician documentation.

Using EHRs to help capture this information also ensures fewer retrospective queries, provides greater coding accuracy, productivity, and, hopefully, both physician and codes satisfaction because more time can be spent on patient care and achieving – and less time learning ICD-10 or doing administratively burdensome tasks.

So on the next couple of slides, starting on slide 76, I have listed some of the ICD-10 examples that I think would be ideal for capturing through EHR templates and prompts and, hopefully, eliminate querying after the fact for this type of information. So the laterality, devices, anatomy, severity, disease relationships – on slide 77, relationships of the condition to the procedure – is it a postop complication – the different fracture types – on slide 78, things like dominant versus nondominant for the hemiplegia, the weeks of gestation, the causal organism, the age of the MI, and so forth.

So I think that – those are all types of information that, I think, if we captured up front in the EHR documentation at the point of care, it would be easier for everyone in the long run and we'd have really high-quality documentation and high-quality coding.

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Now, on the next few – couple slides, I'm just going to walk through a couple of the persistent myths that keep coming up. And one issue that keeps arising is the large increase in the number of codes and the supposed difficulty this will create in being able to identify the correct code.

Well, does the increased number of codes increase the difficulty? No. Just as in a phone book or a dictionary, if there's more phone numbers and there's more words in the dictionary, it doesn't make it harder to use either of those resources. If fact, it's a whole lot easier than if you're looking for a word in the dictionary or a number in the phonebook and it's not there. Then you're very frustrated.

Also, just like a dictionary, the ICD-10 code set may have lots of codes. But, people only use some words in the dictionary very commonly; other words they never – they never use. And it doesn't really make it more difficult for them to use the dictionary because there's a lot of words there they don't typically use. That's also true in ICD-10-CM and the codes. Many of the codes have very specific uses, say for public health or worker compensation cases or are regional issues or specialty-specific and would not typically be used by many providers.

The increased specificity of ICD-10-CM and the use of more up-to-date medical terminology makes the codes easier to assign than ICD-9 codes because the more ambiguous the code is, the harder it really is to identify the correct code than if the code is very clear and unambiguous.

As I note on slide 80, an individual physician doesn't use all of the codes in a classification system. Physicians only use a subset of codes. And we still have the alphabetic index, as well as other coding tools to help facilitate the coding process.

On slide 81, another issue we hear a lot is people wanting to use the GEMs – the General Equivalence Map – instead of coding. And the map should not be used to code medical records. Mapping simply provides a linkage between a code in one set and an equivalent in the other code set without any consideration of context or specific patient encounter information, whereas coding involves assigning the most appropriate code based on documentation, knowledge of codes, the other codes in the medical record, and coding guidelines. So mapping is not the same as coding.

And mapping really has very limited functionality and is primarily used for translating code lists or tables of codes where all you have is a group of ICD-9 codes and you need to convert them to ICD-10 or vice versa. When you have clinical description or medical record documentation, it should be coded directly from ICD-10 because that's where you're going to get the much more accurate codes assigned.

And on slide 82, we've heard a lot about the impact on coding productivity. There's obviously, going to be somewhat of a learning curve as we move to ICD-10. However, as some recent studies have shown – have demonstrated, the coding productivity for outpatient encounters and professional services will be much less impacted by the

ICD-10 transition than for inpatient admissions primarily because the outpatient coding is not affected by ICD-10-PCS, which is much more different than the ICD-9 Procedure Coding System. Because ICD-10 is similar in structure to the ICD-9 Diagnosis Coding System, coding productivity will not be as adversely impacted. But, of course, there will be, at least, some minor impact just because it's a new system and the codes are different, particularly for people who may have memorized the ICD-9 codes.

Additional Resources

On slide 83, I just wanted to briefly comment, for those of you who want to know how to get answers to ICD-10-CM coding questions, the American Hospital Association serves as the clearinghouse for ICD-10-CM and ICD-10-PCS questions. I've listed a link there for the online process for submitting coding questions to them. You do need to submit a copy of the identified medical record with the question. And they will not answer payment policy questions, only coding questions. So for payment policy questions, you need to contact the relevant payer.

And on slide 84 through 87, I've listed some of the resources that are on the AHIMA website. Many of these resources are freely available. And so I hope many of you will avail yourselves of these resources.

On slide 87, the last one there, the Universal Use of ICD-10 in the U.S. is one of our newer resources. And this is sort of a set of talking points for people to use to educate their noncovered HIPAA – non-HIPAA-covered entities who may not be transitioning to ICD-10 or thinking they're not going to transition to ICD-10 at this point to basically advocate for everyone adopting ICD-10 so that we're all using the same system and what the advantages of all being on the same code set are.

And at this time, I will turn it back to Leah for the Q&A.

Question-and-Answer Session

Leah Nguyen: Thank you, Sue.

Our subject matter experts will now take your questions about ICD-10 coding. But before we begin, I would like to remind that 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. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional question as time permits.

Alright Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Please note, your line

will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference.

Please hold while we compile the Q&A roster. Your first question comes from the line of Nina Barlow.

Nina Barlow: Hi. Yes, I just had a question regarding – is there a list available of what states require the external causes of morbidity?

Sue Bowman: This is – is it OK to answer the question?

Leah Nguyen: Oh yes, go ahead.

Sue Bowman: I – this is Sue. I was going to say I do not have a list, and I don't – I don't know if one is available. I don't know if anybody at CMS knows the answer to that question.

Pat Brooks: This is Pat Brooks. We in the room do not know the answer to the question. But if you are concerned, you should contact your local state officials to see if it's mandatory or not.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Patricia Komosinski

Patricia Komosinski: Hi, thank you very much for taking my call. I'm trying to get clarification from slide 69 regarding coding on the fracture. I work in an IPR and I'm trying to determine if I would continue to use the same code assignment or because we do therapy, we would switch to the subsequent encounter for the seventh character.

Sue Bowman: So, you primarily provide therapy, is that what you are saying?

Patricia Komosinski: It's an inpatient rehab – acute inpatient rehab. And I'm just trying to clarify if the coding would continue on with the A or if it switches to subsequent encounter as your example on slide 70 did.

Sue Bowman: It's hard to – for me to say for sure without knowing exactly what the – what the scenario is. Typically, for encounters that are focused on therapy as opposed to say, correcting or treating the acute injury itself are generally what falls into the subsequent encounter category. If you have a specific scenario that you're interested in or have a question about, I recommend that you submit it to AHA on that link I gave on slide 83.

Patricia Komosinski: Sure, thank you very much.

Operator: Your next question comes from the line of Carolyn Lewis.

Carolyn Lewis: Hi, I just had a question about the hospital physicians. Are they going to be instructed into making more clarifications on the type of fractures as used in the example, whether it be closed or open, so that we know to code either closed or open?

Sue Bowman: I am not sure who you're suggesting – is going to instruct them. A lot of providers and hospitals are providing education to their in-house physicians on what documentation is needed and, certainly specialty organizations are also providing education to their physician members as well. So I guess, it's probably part of your facility's responsibility to ensure that the physicians know what types of documentation they're going to need to be providing under ICD-10 to be as specific as possible.

Carolyn Lewis: OK, thank you.

Operator: Your next question comes from the line Linda Sein.

Linda Sein: Hi, good afternoon. I'd like to know if you would know about when the LCD policies would be released.

Leah Nguyen: Can you hold on for one moment?

Linda Sein: Hello.

Leah Nguyen: Hold on for one moment. We'll be right back with you.

Linda Saint: Thank you.

Leah Nguyen: Hello, we don't have the correct subject matter expert in the room right now. But if you want to go ahead and email your question to the address listed on slide 88, I can get that over to them.

Linda Sein: Oh, thank you so much. Appreciate it.

Leah Nguyen: Alright, thank you.

Operator: Your next question comes from the line of Katherine Hilliard.

Katherine Hilliard: Hi, my question is, let's say you have a patient who comes in and they're diagnosed with a sprain. The x-ray does not show a fracture. And then, a week later, they come in for what is supposed to be subsequent or routine care just to make sure everything is going well. You re-x-ray it and now, you have a fracture. Is that now an initial encounter because there is now a fracture and it's a new diagnosis? Or is it still a subsequent encounter?

Sue Bowman: Well, it's hard to sort of answer specific coding questions on the fly. You might want to submit that one to the address as well. It sounds to me like it would still be

initial. But, I'd really have to see the specifics of the scenario and what had happened in the – in the different encounters.

It's just important to just sort of keep in mind that if – that the – that the initial encounter is really any encounter that is focused on direct treatment for correcting that injury itself, and subsequent encounter is for either just followup, recovery kinds of stage, and/or returns with things like malunions and nonunions currently fall into that subsequent encounter bucket as well because they have special seventh characters for that. So, that's kind of how to think of the distinction. I don't know if that helps at all. But ...

Katherine Hilliard: OK. So, I guess, you're saying it's more like a case-by-case basis as to whether or not that's considered ...

Sue Bowman: It is, yes.

Katherine Hilliard: OK. OK.

Sue Bowman: I know it's – I wish I could have, you know, one answer for every scenario. But, the only overarching principle is the idea of the – of whether or not it's active treatment focused directly on the injury itself vs. followup, aftercare therapy, or a complication such as a malunion or nonunion.

Operator: Your next question comes from the line of Linda Holsey. And Linda, your line is open.

Your next question comes from the line of Maria Ferrera.

Maria Ferrera: Yes, hi, good afternoon. I have a question concerning procedural coding with approach. We've had a little difficulty here discussing when you have a fetal monitor and it's a scalp pH that they are doing on the baby, is the approach considered external or are we actually considering the fact that it's through a natural orifice? And that's what we're trying to capture with the approach, not really the destination of where the scalp, you know, electrode is being placed, which is external on the baby's scalp. But, the approach to get there, I would assume, is, you know, through a natural orifice, the same thing we're having trouble with turbinectomies. They're going through the nose. But once they get to where they need to be, they make an incision. So we weren't sure if that's considered opened or is it, again, through a natural orifice.

Sue Bowman: I'm sorry. I'm afraid we can only answer questions that are directly related to the focus of this Webinar, which does not include PCS. And also we are not able to answer specific coding questions on this call. So I would recommend that you submit your question with the medical record documentation to the link I provided to AHA.

Maria Ferrera: Oh, OK, I'll do that then. Thank you.

Operator: Your next question comes from the line of Toni Gibson.

Toni Gibson: Hi. Part of my question was already answered on the external cause list when they are required if there was a list. I know we need to contact our local state officials. Is that specific to hospitals if it's required or, is it private practices as well that could be required to use them?

Sue Bowman: I believe it could – it could involve practices as well, although I think some states are more specific to hospitals. But there are certain situations when they're required. And it is pretty much state by state – how the requirement is worded.

Toni Gibson: OK. And then, after there is the state-by-state mandate, it could also then trickle down to payer mandate?

Sue Bowman: Yes, yes.

Toni Gibson: OK.

Sue Bowman: Some payers might require it, like – it's particularly valuable, for example, for workers' comp payers so some of them may require external cause codes because it provides them with some – a lot of additional information.

Toni Gibson: OK, thank you.

Operator: Your next question comes from the line of Stephanie Coward.

Stephanie Coward: Hi. My question is on episode of care encounter. We have patients who might come in –they're children. They might come in for closed reduction of a fracture with splinting. They're put under in our hospital. But maybe 7 or 10 days later, that fracture has displaced and they come back in for an ORF. Is – when they come back in the second time, is it still an initial encounter? Or it is for delayed healing?

Sue Bowman: That would really depend on the documentation which – that would be, you know, a clinical assessment that could relate to how long after the initial injury it occurred. So that again, as I had mentioned to the – to the previous caller, it was – it would be a case-by-case scenario. And if was unclear in the documentation, I would recommend going back to the physician and clarifying that.

Stephanie Coward: Well, these are like a week later – 7 days.

Sue Bowman: Well, again, you know, it would depend on how the physician – I mean different injuries could be considered differently so – and I'm not a clinician. So I think you would really need to get clinical input on that question.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Traci Barnes.

Traci Barnes: Hi, I was just wondering on – when you were talking about getting codebooks and things, when you were referring to slide 37 – I don't know if it had anything to do with slide 37 or not. But, you said that there was a free place that you could get that information. But, you didn't say or include that link or anything. So where is it that we go to get that?

Pat Brooks: This is Pat Brooks with CMS. If you'll look at slide 11, you'll see the general ICD-10 website. And on that website, if you look on the left side, you will see for fiscal year 2015, we posted files for the fiscal year 2015 ICD-10-CM. And that is the Diagnosis Code System. You can open that and see a number of files there. And you'll find the index files – the tabular files that Sue went through so well. You'll also see a complete list of code titles. So each year, when you look down the left side, you'll see – you'll see we have 2 years posted, the prior year and the next year. You'll see, in essence, what is a free codebook.

Traci Barnes: So the place on slide 11 that says CMS ICD-10 Industry email, no?

Pat Brooks: The one at the very top, the ICD-10 website. It's the link to the website.

Traci Barnes: Oh, OK. I see.

Pat Brooks: And you follow that, you'll see a lot of information on that page. But on the left side, there are links for – one of them is for ICD-10-CM, the current year. There's another link for ICD-10-PCS, the current year. So you can find those. We update them every year on the left side. And you'll find, in essence, a free electronic version of the codebook that Sue was talking about.

Traci Barnes: OK, and so what is that called? I'm looking at that right now. So ...

Pat Brooks: So, on the left – if you look on. Have you – you would have to open up, for instance, the fiscal year.

Traci Barnes: I did. I'm on that right now.

Pat Brooks: You've got the fiscal year 2015 ICD-10-CM. You would open that page, and there'll be a number of files. And some of them are merged together. But you – when you'll open them, you'll see there's tabular – there's something called tabular and indexes. And that's what Sue was talking about.

Traci Barnes: OK, great. I see it. Thank you.

Leah Nguyen: Thank you. Victoria, it looks like we have time for one final question.

Operator: OK. Your last question comes from the line of Norm Eunez.

Norm Eunez: She just asked the question I needed to know, thank you.

Leah Nguyen: Thank you.

Operator: OK, your next question is from Oscar Lerma.

Oscar Lerma: Hello, I was wondering – so it sounds like the requirements for submitting ICD-10 codes has been pushed back a year. Does that mean after that date, will any payers be exempt from accepting ICD-10 diagnosis codes or from – you know, from, yes, accepting them?

Denesecia Green: Yes, hello. We issued a statement to – you know, stating that we intend to set the compliance date October 1, 2015. And then we extended the usage of 9 through September 30, 2015. So, we expect people to use ICD-10 codes as of October 1, 2015, and beyond. I hope that helps to answer the question. Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can e-mail it to the address listed on slide 88.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 89 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Lastly, 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 professional organizations for participation in MLN Connects Calls. Questions concerning continuing education credits should be addressed to your organization.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on More ICD-10 Coding Basics. Have a great day everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-