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National Provider Call Transcript

Centers for Medicare & Medicaid Services
ICD-10: Preparing for Implementation and New ICD-10-PCS Section X
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Operator: At this time, I'd 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 you have 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'm 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 ICD-10, Preparing for Implementation and ICD-10-PCS Section X. MLN Connects Calls are part of the Medicare Learning Network®.

It's not too late to get ready for ICD-10 implementation on October 1st, 2015. During this call, CMS subject matter experts will present strategies and resources to help you prepare, also learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. 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 web page, click National Provider Calls and Events, then select the June 18th 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 credit may be awarded by professional organizations for participation in MLN Connects Calls. Questions concerning continuing education credit should be directed to your organization.

At this time, I would like to turn the call over to Denesecia Green from the Office of Enterprise Information for a presentation on preparing for ICD-10.

Presentation

Denesecia Green: Thank you Leah. Good afternoon everyone. My name is Denesecia Green, I'm the Deputy Director of the National Standards Group. I'm very excited to be with you this afternoon. So today I'm going to walk you through a few preparation steps so that you're getting all of your ducks in row for ICD-10.

But I want to let you know that ICD-10 is really foundational to our health — to our nation's health care. And we really want to make sure that everyone is prepared. We're

about 104 days away. Certainly, there's still time to get ready. And help is here. We have free resources, tools, and testing available to everyone.

Get Ready for ICD-10

Today, I'm going to cover about three areas: facts about common misperceptions on ICD-10, how to prepare for ICD-10 with a five-quick-step action plan, and then the CMS resources that we have available.

So let's talk about some of the facts. And so ICD-10 is set. The date is set for October 1, 2015. And what we want you to understand is that there are not that many codes. Yes, you have to take a look at the codes that you use. And over half of the codes really are laterality. And if you look at the code set by category, some of the codes have actually been streamlined in ICD-10.

I think one of the things that we have to keep in mind is, who are the patients that we take care of? And that will help to dictate what codes you're going to be using certainly. Also, there's tools out there that show you, by specialty, what are the most common codes. So we really are trying to put together some of those tools using physician input to make it easier for you.

The other thing that we heard is that, you know, "ICD-10 is going to change everything." Well, ICD-10 doesn't change everything. You use very similar processes that you use today for ICD-9.

Another question out there is, you know, What is changing? So, your outpatient and your office procedure code aren't changing. Physicians will continue to be paid using the Physician Fee Schedule. And also, Medicare Fee-For-Service providers can test with CMS up through the transition. Acknowledgment testing is available through September 30, 2015, but certainly, we encourage you to get started today.

And so, what if you have some questions about submitting ICD-10 codes come October? Well, if you cannot submit an ICD-10 claim electronically for any reason, so if your system is not working, you can certainly utilize our free billing software. These tools are downloadable on our site. And also the Medicare Administrative Contractors offer portals where you can submit your claims into — about half of those MACs offer that service. And lastly, there's also the option of paper claims if you qualify for the waiver.

Another thing to keep in mind is that practices must use that ICD-10 code in order to submit claims for dates of service performed on or after October 1. Again, reimbursement for outpatient and physician office procedures will not be determined by those ICD-10 codes.

We've also heard from many groups that, you know, the costs might be a factor or a barrier to provider preparation. But what we've learned over the last few years is that

many vendors have included the ICD-10 upgrade within their systems, and many are either no cost or low cost.

And there are multiple free trainings out there through CMS, through a number of our training partners. We have actually entered into a training collaborative with AHIMA, AAPC, and other groups. They have been phenomenal at offering great resources out there for providers. And also ICD-10 codes are posted on our site. They are always available for download.

So definitely, it's time to transition now. You know, ICD-10 offers those benefits that we really want to be able to put into practice. It improves the coordination of patient care across providers over time. So someone with a complex health condition with a care routine, this is very beneficial in making sure that everyone knows what's going on with that patient. And certainly, ICD-10 will advance public health research, for example, Ebola and other things that can be tracked through population health and emergency responses.

And also, looking at how health care is shifting to innovative payment methods and driving quality. ICD-10 helps to support that and helps the provider to demonstrate the quality of care they're delivering to the patient.

Steps Providers Should Take

So let's talk about those quick steps that all providers should take a look at as they're moving through their ICD-10 transition, and I'll go through them quickly and then get into a little bit more detail on them.

So number one, make a plan; number two, train your staff; number three, update your processes; number four, talk to your vendors and payers; and five, test your systems and processes.

So let's go back up to make a plan. I mean, this is really about reviewing your super bills, looking into your practice management system. Some practice management systems allow you to run a report, say, your high volume codes or your top 25. Start there.

Training your staff. Really looking at documentation trainings and coding trainings. These are essential for ICD-10.

And updating your processes. Look internally, review your encounter form, your policies and procedures. Get everyone in your practice onboard.

Number four, talk to your vendors and payers. What you want to do here is to reach out to your vendors and payers. These are the entities that you work with all the time. And so you really want to engage them in that readiness discussion. Do I have what I need?

When will I get what I need? And do we — are we all on the same page moving forward for ICD-10?

Number five, test your system and processes. This is where you're working with your vendors to test your internal systems, ensuring that things work properly, that they can answer your questions, and that if anything does happen, that there's some trainings or a call center available for them to answer your questions.

Also testing with your payers. There are many payers out there that are offering testing as we speak. And then reviewing those test results to ensure that you're getting back what you expected.

So again, there is still time. Help is here. And there's a wealth of resources out on our CMS website.

And remember, ICD-10 claims with a date of service on or after October 1, 2015, will be rejected. And there is no opportunity for dual processing. We really want you all to prepare now. There are free resources, tools, and training available, not just with CMS, but across the health care industry.

****Post-Call Clarification: And remember, ICD-9 claims with a date of service on or after October 1, 2015, will be rejected.****

So let's take a look at some of those resources that are out there.

Stay on the Road to 10. This is our ICD-10, Road to 10 Program. It really is a program of training — onsite trainings, website resources. And also, we get physician input on all of the tools and resources that we're developing.

There's a wealth of videos out there that we will walk you through in introduction of ICD-10. And as you want to delve in further, there are also multiple videos on a number of clinical conditions as well. There's also some coding information out there for diabetes, as an example. There are some CME and CE opportunities still out there.

We encourage you to use those fact sheets, tip sheets, you name it. Really to move your — and to sort of jump start your ICD-10 transition, we have the latest news page. And also, if you join our Road to 10 website, you'll see that there's new a feature. There's an interactive case studies out there that will really allow you and your staff to go in to do some practice sessions before October 1.

So we encourage you to sign up for our ICD-10 email updates and also follow us on Twitter. I mean, there's a wealth of resources. We hope to continue these conversations with providers. We're working very closely with the health care industry at large. We're

hosting one-on-one calls with health plans, clearinghouses, vendors, and the like to all join together to help providers get ready.

So thank you for your time today. I look forward to your questions. Thank you. Leah?

Keypad Polling

Leah Nguyen: Thank you Denesecia. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate account 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.

Holley, 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.

Please hold while we complete the polling.

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. Once again, please continue to hold while we complete the polling.

Thank you for you participation, I'll now turn the call back over Leah Nguyen.

Presentation Continued

Leah Nguyen: Thank you Holley. At this time, I would like to turn the call over to Pat Brooks from the Hospital and Ambulatory Policy Group for our presentation on the New Technology X Section in ICD-10-PCS.

New ICD-10 Technology Section X Codes

Pat Brooks: Thank you Leah. I'm pleased to be discussing the ICD-10-PCS X codes today. We will be creating 14 of these new X codes that'll be implemented on October 1st, 2015. And the X codes are solutions for a challenge CMS has faced trying very hard to have unique, identifiable codes for new technologies.

Now, turn to slide 15, we'll talk briefly about some background information. Denesecia covered some of these. She mentioned that October 1, 2015, is the compliance date for ICD-10-CM diagnosis and ICD-10-PCS procedures. And the diagnosis codes, the ICD-10-CM, will be used by all providers in every health care setting.

Now, the ICD-10-PCS codes that I'm going to be talking about today will only use — be used for hospital claims for inpatient hospital procedures. So ICD-10-PCS will not be used on physician claims, even for those physician claims for patients' visits. So those of you on the phone today from physician offices will not be using the X codes that I'll be discussing.

If you'll turn to slide 16, I'll give you a brief overview of how code updates are made. There's a committee called the ICD-10 Coordination and Maintenance Committee that discusses updates to both the diagnosis and the procedure coding system. And there's a link on slide 16 to the ICD-10 coordinating — . If you'd never done so, I would really urge you to click on that link and find out the kind of issues that the committee discuss and handouts we provide. The last meeting was in March, and we have handouts from that March meeting.

The next meeting is going to be September 22nd to 23th in Baltimore at CMS facility, and you can register and come and attend the meeting in person. Or, if you like, you can participate with these C&M meetings, as we call it, by live stream. So in the comfort of your office you can watch the C&M procedures online. We also provide free phone lines to listen to the meetings. So I would encourage you to listen to the next meeting. Or if you wonder what happened at past meetings, you can watch those live streams views.

If you have a request for a code update for the September 22nd –23rd meeting, those requests would have to be received by July the 17th. We usually require those requests for code updates for about 2 months prior to the next C&M meeting.

And now, if you'll turn to slide 17, we'll discuss this X codes and a little history. We received a public request to create a new section in ICD-10-PCS for new technologies. And this request was made at the September 2014 Coordination and Maintenance Committee meeting.

There was a lot of frustrating — frustration voiced because we were under a partial code freeze, and people were very concerned about putting very specific new technology codes within the main body of PCS. And they also expressed concerns that some of the very detailed code requests are not things that typically are captured within the body of ICD-9-CM or ICD-10-PCS. And it was suggested that if we create a separate section, that we would have the ability to provide a way to easily capture — very specific new technologies.

We thought this was a good idea, and so we brought that issue to the March 18th, 2015, Coordination and Maintenance Committee. And we illustrated how this could be applied to the issues requested — the new issues requested at the March meeting. And so if you want to see some history of that and how people request a code, and options are always given at the meetings.

One option is always not to create any code. A second option would be to put the code in the body of the PCS such as in the medical/surgical part, or perhaps the administration part. And a third option might be to create new X codes, and we got comments from the public on this concept and which approach would be best to use.

For this new X code, they'd really thought it would work well for things that we consider more administration of drugs or use of supplies. But it's also useful for things that are not easily entered.

Now after this meeting, if you wanted to read about the X codes a little more, we posted on slide 17 an article, MLN Matters Article SE1519. It gives you a very good overview of the X codes and helps you understand what they're all about.

We'll move on to slide 18, and I'll mention that we do post updates to the ICD-10-CM and ICD-10-PCS annually. And in early June this year, we posted the 2016 files. So those of you from a physician office that have maybe not yet gotten an ICD-10-CM codebook, as Denesecia mentioned, you can go on this website right now and look at the tabular and index coding system to see what it's all about. Now I think once you start using it more frequently, you'll probably want to get a codebook, just like you'd buy CPT codebooks — each year.

And on slide 18, you'll also see that we've been under a partial code freeze for several years, and people have been quite adamant about minimizing the number of codes added. And some people even supported creating no new codes. Well clearly, we have to create new codes for new technologies for revisions and diseases, so those have been our criteria of which codes we would create.

For October 1, 2015, you will see that we have no new diagnosis codes created when you look at the 2016 files. When you look the ICD-10-PCS files, you'll see that we created 36 new procedure codes. And of those 36, 14 were X codes. The code freeze is going to end on October 1, 2016, so we will no longer have these very strict criteria of only considering codes for new diseases and new procedures and new technologies.

If you'll now turn to slide 19, I'll get into a little more detail about what section X is all about. You'll see that we have a twofold goal for creating this section.

One was to create codes that uniquely identify procedures requested via the new technology –or that captures services not really routinely captured in ICD-10-PCS. And a

good example of a procedure that's not typically captured in either ICD- 9-CM currently or in ICD-10-PCS was a topic that was discussed at the March 2015 C&M meeting, and it was — this is for organ perfusion for transplants.

And those of you who want to read about this one can find it in our handouts posted on the web page on pages 35 through 37. This is a procedure performed on an organ from a donor to see if it can become a viable organ to be used or not, and it's not typically the kind of thing that you would capture in a procedure coding system. So consideration is being given to putting it in X code section will if not – be

Features of the Section ICD-10 X Codes

Continuing on to slide 20, I'll tell you some important features of the X codes. One is that the X codes use the same root operation values as their closest counterpart in other sections of ICD-10-PCS.

So the good news is you won't have to learn a whole set of new reoperations simply because you want to find an X code. A second feature is the X codes is for types of techniques —technologies that are not usually captured by coders or do not usually have the desired specificity within the current ICD-10-PCS structure required for new technology approval.

An example of this is drugs. We've received a lot of pushback from people about new codes because we put them into ICD-9-CM and ICD-10-PCS, and they were very specific to a brand name drug. And people felt like the coding system should be more generic. And they have pushed us to put things like this or devices into a separate HCPCS system or national drug codes or elsewhere. And the X codes allows us to fold all of these within one setting, and hospitals look to one coding book to capture all of these things. So that's why the X codes works well.

Turning to slide 21, we'll mentioned that the codes for the new technologies are consistent with the current ICD-10-PCS code and make them — that are consistent with it may still be created within the current ICD-10-PCS structure. In other words, just because something's a new technology, we may or may not put it in the X code chapter. We may decide that it belongs better in the administration med/surg or another part of the system.

Each time a code request is made, it is taken to the ICD-10 Coordination and Maintenance Committee. And at this meeting, the CMS staff will provide options for the public to discuss and provide feedback on. An option would be, as I discussed earlier, not creating the new existing code. Our next option might be to put a new code into the body – this therapy, put this code into the new X code section. So the public will be given the opportunity on each request to provide feedback.

Moving on to slide 22, I show you a slide of the structure of ICD-10-PCS X codes. You'll see that the first character is a letter X, so you'll all be able to spot these X codes very quickly. The second character is the body system/region value. The third character, the root operation. The fourth character, body part. The fifth character, the approach. The sixth character is the device/substance/technology. The seventh character is information indicating the year it was created. And Rhonda Butler will be going through these soon and you'll see that for the first year this will be used, and she'll be explaining that rationale to you.

OK. You'll see that, consistent with the general architecture of ICD-10-PCS, each of the seven characters has a consistent definition within the section. So we don't mix up the definitions within one section. And that the third, fourth, and fifth characters specify the root operation, the body part, and the approach, respectively. Because that type of information that's defined in those chapters' characters are the majority of the ICD-10-PCS sections.

Moving on to slide 24, we point out that we've had questions about the X codes, and people ask, well what if you want to modify the X codes, or maybe even somebody wants to request that you delete an X code and move it into the medical/surgical section, can that be done? And how can that be done?

And the answer is, we will treat these X codes in the same manner that we do all requests for codes. If one wants to make a request that any code, be it X codes or other codes, be created, revised, or deleted, you have to make that request to the ICD-10 Coordination and Maintenance Committee. And that request goes in about 2 months prior to the meeting. At the public meeting, we'll lay out the options that there might be. We might describe a person's option of perhaps deleting an X code and creating a med/surg code, and if so, we would give the public an opportunity to discuss this.

If we get the request about X codes, then they are in the X chapter, they can be used easily and there's no worry about them disappearing. There's no sundown affect for them. They could be used forever unless that there was a request to modify the code.

Now Rhonda Butler is going to go through some examples of ICD-10-PCS codes. They're going to create them on October 1st, 2015 …

Open mic

Someone's phone line's open.

Anyway, we'll go on slide 25, and I will show the single ICD-10-PCS X code guideline. And we could just read it together:

"Section X codes are standalone codes. They are not supplemental codes. Section X codes fully represent the specific procedure described in code title, and do not require any additional codes from other sections of ICD-10-PCS. When X codes contain a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, nonspecific code in other sections of ICD-10-PCS."

Now this guideline is included in the 2016 ICD-10-PCS guidelines posted on our CMS website.—And if you wanted to look at all the guidelines together you could, and you would find these new guidelines for ICD-10-PCS X code.

Moving on to slide 26, I'll give you a brief guideline example. In this example, we have the new X code, XW04321 Introduction of Ceftazidime-Avibactam Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 1. That's the code title. And you can report this code to indicate that you're giving this new anti-infective drug and that it was administered. You would not have to go into the administrative section of ICD-10-PCS and choose a 3EO code that would say, in general, I administered an anti-infective. No, you would simply use the X code. It would tell you everything you needed to know.

And with that, I'll stop and turn it over to Leah.

Leah Nguyen: Thank you Pat. I'd now like to introduce Rhonda Butler from 3M, who will be discussing the New Technology X codes.

New Technology X Code Examples

Rhonda Butler: Thank you Leah. I'm going to cover 14 – the 14 new technology section code examples by giving you three different examples of the basic types of new technology codes that have been created for this year's update for October 1, 2015.

And looking at slide 28, I'm going to give you an example of the first basic type on — that Pat mentioned is a common reason that we have codes in the new section X — and that is for new technology drugs. She just covered one from — that's listed in the guideline as the Ceftazidime, but this one is called Blinatumomab. It's a new antineoplastic immunotherapy drug, and it's administered by intravenous infusion, and it treats certain special types of leukemia.

For this new technology drug, this year, two section X codes were created, one if it's infused by a central vein, and one if it's infused by a peripheral vein. And there are two index entries that have been added to the index to assist coders in finding the correct code.

You can see one of the main terms is under the name of the drug, Blinatumomab, and the other is under the main term New Technology. Now this main term New Technology

will be updated every year, and you can imagine that the new technology will allow us to list all the technology codes in a single place. So you can see at the glance all the codes that are in the New Technology section just by looking under this main term New Technology.
Now, moving on to slide 29, this example is shown in the PCS table format. There you can see the table that shows not only Blinatumomab, but all of the section X codes for infusion of new technology drugs that have been created this year for October 1, 2015.

So this slide is a little bit more colorful than the typical PCS table, but it's the same view of how it would be in the PCS PDF of the new code. So we have the section on top and the body system. As Pat mentioned, the second character is the body system. The third character — it's going to give the same root operation definition as is used in the section 3 introduction section of PCS.

So we have that consistency between the new technology and the way this drug would be coded in the — consistent with other infusion or injection codes. So the definition is exactly the same. You can see in the fourth character, the body part is peripheral vein and central vein, the approach is percutaneous. And then this sixth character value is kind of the area where you see — of the sixth and seventh characters, point out the key aspects of what makes these codes unique and what tells you the key information about a specific code.

So you have Ceftazidime is one of the new tech drugs, and you have Dabigatran Reversal Agent is another new tech. drug this year, another anti-infective for certain fungal infections, and then the last one is a new tech antineoplastic that I've been talking about, Blinatumomab.

Now, the seventh character, the qualifier, it just says New Technology Group 1, and as Pat explained, that's something that's unique to section X. And briefly, it allows us to be able to recycle the values to make them as consistent as possible with the section that they are most closely related to in PCS. And so every year — the plan is that every year this qualifier changes new technology group. We're starting with New Technology Group 1 for this year, for October 1, 2015. And then if any new technology codes were created the following year, they would be New Technology Group 2, or — and they would be valid beginning October 1, 2016.

And it's really — it's not anything specific that coders actually need to know. It doesn't affect the code itself. It's just a way of keeping this section X as flexible and useful as we need it to be. So that's what the new technology group is all about. And if you're interested in more information about that, you can click the link for the MLN article that Pat referred to and read a bit more about that.

Moving on to section — slide 30, I'm going to cover another section X example. So those are the new technology drugs, and those are the majority of the section X codes that

were created this year. There are 14 new codes in section X. There's a complete list of those; it's at the end of this presentation. And so you've just seen the new technology drugs — this other technology that was covered in section X this year and new codes were created — is called Orbital Atherectomy. I'm on slide 30.
Orbital Atherectomy is a new catheter-based technique for treating severely calcified coronary artery lesions. There's four codes in section X. They specify the number of coronary arteries treated that — consistent with how they are working in the regular medical/surgical section. So other techniques for taking out coronary artery plaque would be coded in a similar way using the number of coronary arteries.

There are three index entries that will assist coders in finding these new technology codes. One under the main term Extirpation, you can see that there's a subterm there for the Orbital Atherectomy Technology, one under the main term Orbital Atherectomy Technology. And then again, all the new technology codes are under the main term New Technology.

Turning to slide 31, you'll see a rendering of the table in section X, table X2C. And again, the body system, Cardiovascular System, is kind of a super system that allows us to put all the cardiovascular body part values in section X in the same body system, and the root operation Extirpation is the same root operation that would be used in medical/surgical for taking out coronary artery plaque. So other Atherectomy codes are also coded to the root operation Extirpation, so that keeps the data consistent and easy to find.

The body part value, you can see. As I mentioned in the earlier slide, there are four body part values, depending on how many coronary artery sites are treated. The approach is percutaneous, and again, that sixth character gives you really the key aspect of whatever this new technology is. In this case, it's not a substance, but it's the technique, it's a surgical technique. So it's one of the technologies that's coded in.

Moving to slide 32, we have our last section X example for this year, which is an intraoperative knee replacement sensor. This sensor is a disposable tibial insert. It's used only during the surgery to replace a knee, and it's used in order to aid the surgeon in placing that prosthetic joint component during the surgery.

So there are two — like Pat said, this is — these are first things that typically would not be necessarily coded in the regular sections of ICD-10-PCS or even in ICD-9. This is a disposable component that's used during surgery.

There are two section X codes for this, one for each knee joint. And there are two index entries that have been added to the ICD-10-PCS index in order to help coders find this code, one under the sixth character value — intraoperative knee replacement sensor, and one under the – again, the New Technology main term, it will also be there, and it refers you to table XR2.

On slide 33, you can see a rendering of table XR2, and it shows all of this new section X that's intraoperative knee replacement sensor. Again, the body system is joint, the root operation is monitoring, determining the level of a physiological or physical function, because what this knee replacement sensor does is it gives the orthopedic surgeon very precise information about balancing that new component so they can — the idea is that they can place the component optimally during the surgery.

And you can see the body part values there are right and left knee joints, the approach is open, and, again, the qualifier is New Technology Group 1 for all new codes that were created this year.

Turning to slides 34 and 35, you can see listed there all of the new technology codes that were created for October 1 of 2015. So those are all of the things that I just showed you in those three tables. When they get turned into individual codes and have their code descriptions, you have these 14 codes.

I'll turn the time back over to Leah.

Leah Nguyen: Thank you Rhonda. Our next presenter is Stacey Shagena from the Medicare Contract Management Group presenting on CMS testing plans, results, and opportunities.

CMS Testing Plans and Opportunities

Stacey Shagena: Thank you Leah. And thank you for having me here today to talk about ICD-10 testing. And with this ICD-10 transition and our preparations for the transition and also with all of this testing, I think we are seeing what might be considered an unprecedented level of cooperation across the health care community — cooperation between hospitals, physicians, and their communities; between health plans and providers; and among health plans and other provider organizations that are typically competitors.

At CMS, we are grateful for all the insights and best practices that the groups representing providers, payers, and vendors have shared with us. As we enter into the final stretch, I want to thank everyone for all your work together, and with us towards a successful transition, and to encourage everyone to continue the spirit of cooperation.

Now I'd like talk about what we're doing here at CMS to make sure Medicare and our Fee-For-Service providers are fully prepared for first. We have developed a comprehensive, four-pronged approach that includes CMS internal testing of our claims processing system, provider-initiated beta testing tools, acknowledgement testing, and end-to-end testing.

I'll give you some details on each of these four components now, starting with internal testing. CMS has a very mature and rigorous testing program for its Medicare Fee-For-Service claims processing systems that supports the implementation of four quarterly releases a year. Each release is supported by a three-tier, time-sensitive testing methodology, which includes alpha testing by system maintainers for 4 weeks, beta testing by separate integration contractor for 8 weeks, and acceptance testing by the MAC for 4 weeks. This testing process ensures that our systems will be ready for each change that we make to the systems on our quarterly basis.

CMS began installing and testing system changes to support ICD-10 in 2011, and as of October 1st, 2013, nearly 2 years ago, all Medicare Fee-For-Service claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

In addition to our own internal testing, CMS helps you prepare for ICD-10 by providing provider-initiated data testing tools. These to — tools include the NCD/LCD conversions to ICD-10, the MS-DRG conversion, and the IOCE, or the Integrated Outpatient Code Editor, updates for ICD-10. These testing tools are available from the CMS — for download from the CMS website.

Now I'd like to talk more specifically about the types of testing CMS offers with providers. We are offering two main types of testing, which I describe and compare and contrast on slide — sorry, which slide? Forty, thank you. The slide numbers are different.

On slide 40, we talk about the difference between acknowledgement and end-to-end testing. And as you can see, we've answered some of the major questions that we received between the difference of these two testing offerings.

Acknowledgment testing can be done at any time by any provider that submits electronic claims.

End-to-end testing was limited to a 50 — 50 end-to-end testers per testing round. And those testers had to volunteer and be selected by Medicare. Also, for acknowledgment testing, dates of service are current date of service for test claims. When testing end-to-end testing, the claims must be future-dated to dates of service after 10/1/2015 for the claims to process correctly. End-to-end testing also produces a full test from submit to remit, creating Remittance Advices for testers.

So let's talk a little bit more about acknowledgment testing. Providers, suppliers, and billing companies and clearinghouses are welcome to submit acknowledgment testing claims at any time up through October 1st. In addition, CMS is highlighting this testing by offering — has offered four separate testing weeks.

Those weeks — the last of those weeks was on June 1st through June 5th. Details about the testing week –that testing week will be released from CMS shortly. However, I do have some information about the previous three testing weeks.

The acknowledgment testing from the first three weeks, nearly 3,900 submitters participated and submitted nearly 150,000 claims. The national acceptance rate ranged from a low of 76 percent in November to a high of 90 – almost 92 percent in the March testing. This shows that those testers are learning how to submit ICD-10 claims and that it's improving with each of these rounds of testing. Again, you can continue to acknowledgment test outside of our special testing weeks all the way up through October 1st.

Finally, end-to-end testing. This testing does — does test submission of test claims and receipt of Remittance Advices from Medicare. We've offered three testing periods — January, April, and July. And the final testing period will be this July — begins this July 20th. The testers for this July registration have already been selected and notified that they are – have been selected for testing. And we are preparing the setup process for that testing to occur.

Up to 50 submitters were selected from each of the MACs and, in addition, for July, we submit – select an additional 20 percent of testers to ensure that as many testers as possible could participate in our final, third round of end-to-end testing.

I'd like to share some results from our April end-to-end testing as well. Approximately 875 testers submitted claims for 1,700 NPIs that were registered to test. About 300 of these testers were return testers from January. The remaining were new testers in their first attempt at April end-to-end testing. Twenty-three thousand test claims were received, at an acceptance rate of over 88 percent. The majority of the reasons for rejected claims were not related to ICD-10 but were submission issues on the part of the tester, including incorrect NPI health insurance claim numbers, or HICNs, Submitter IDs, and dates of service outside of the range of testing. Less than 1 percent of the errors for rejection were related to an invalid ICD-9 diagnosis or procedure, and approximately 2 percent related to an invalid submission of ICD-10 codes.

We will have information about the July testing results near the end of August. At this time, I can return the presentation back over to Leah.

Resources

Leah Nguyen: Thank you Stacey. Slides 46 and 47 have information on CMS resources to help you with your transition to ICD-10. Slides 48 and 49 have information on local and national coverage determinations. And slide 50 provides links to other organizations that have additional ICD-10 resources.

Question-and-Answer Session

Our subject matter experts will now take your questions about ICD-10. But before we begin, I would like to remind everyone 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 questions as time permits. All right, Holley, 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 assure 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 in the conference. Please hold while we compile the Q&A roster.

Your first question comes from Judy Rhodes.

Judy Rhodes: Hi, my question is on that July 20th testing, how do we do that?

Stacey Shagena: The July testing registration has already closed, so we've already accepted the maximum number of end-to-end testers for July. However, you are still eligible to acknowledgment test with us. And you can find more information about acknowledgment testing on the MAC's website, or you can give them a call on their EDI helpdesk, and they'll be able to help you set up your test claims.

Judy Rhodes: OK, thank you so much.

Leah Nguyen: Thank you.

Stacey Shagena:: You're welcome.

Operator : Your next question comes from the line of Marilyn Washington.

Marilyn Washington: Hi, we just want to know about if we have picked up a patient in July or August, I mean, I'm sorry, August or September and the services are continued to October 1st, how do we – do we have to change the ICD codes or how do we bill those patients?

Sarah Shirey: Hi, this is Sarah Shirey of the Provider Billing Group at CMS. I will refer you to our Special Edition Article SE1408. This article describes patients for claims that span

the October 1st, 2015, date. And that includes inpatient, outpatient, DME, physician— everything is represented in that article.

Marilyn Washington: OK.

Leah Nguyen: And on slide 47 of the presentation, if you click on the link there, we have a list of all of the articles related to ICD-10.

Male: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Soria Sastri.

Soria Sastri: You said — thank you for taking the call. For a billing, should we start with the ICD-10 billing even from now, when we are confident that we are putting in? Or can we submit both ICD-10 and ICD-9 as for practice?

Sarah Shirey: This is Sarah Shirey in the Provider Billing Group. ICD-10 codes are only acceptable for billing with dates of service on or after October 1st, 2015. So you cannot out-bill those now.

Soria Sastri: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jennifer Burgel.

Jennifer Burgel: Hi, I just had a question about slide 9, bullet number 8. Reimbursement for outpatient and physician office procedures will not be determined by ICD-10 codes? I bill for an outpatient surgical facility, I don't — I kind of don't understand what it means, if you can clarify that for me.

Leah Nguyen: Pat, do you want to address that?

Pat Brooks: Yes. What we were trying to state there is that currently outpatient bills are based — the payment amount is based on CPT codes and HCPCS codes.

Jennifer Burgel: OK.

Pat Brooks: And so ICD-10 CM diagnosis codes, which you will also be using, that doesn't affect your payment amount. It may affect any edits – payment edits that exist, but the payment is going to continue to be based on those CPT codes.

Jennifer Burgel: OK, thank you very much.

Operator: Your next question will come from the line of Melissa Selsor.

Melissa Selsor: Hi, it's Melissa Selsor at Family Facets. Can you please walk us through how to do the acknowledgment testing and give us the specific website and links?

Stacey Shagena: Yes, and we have — I'm sorry, I have this CMS article, but each MAC website on their EDI page has information about acknowledgment testing. There is only one or two fields that need to be updated to submit the ICD-10 acknowledgment test code. And the article number, I believe we've got it here...

Leah Nguyen: On slide 47, if you want to click on the link there, we have a complete list of testing resources.

Stacey Shagena: Correct. So, there's an article there I believe related to 8858, but there's an article there related to ICD-10 acknowledgment testing, and it will give you additional information on what needs to happen to submit an acknowledgment test code — claim.

Leah Nguyen: Thank you.

Operator: OK, your next question will come from the line of Amanda Foust.

Amanda Foust: Hi, Amanda Foust from QuickMedical. I have a quick question regarding the X codes and the seventh character as far as the date. Could you go into a little bit more detail regarding that? It's a little bit confusing with me. It says it's information indicating the year created, but is it going to have the year or are they just going to go by technology and group 1, 2, 3, and so on?

Pat Brooks: Rhonda, do you want to take that?

Rhonda Butler: Sure. It will not contain the year. The reason is because sometimes a new code will be created and then the — for whatever reasons, the new technology codes will not be used that year. But it really gives you a rough example — a rough estimate of when the code has been created, but it's not meant to tell you exactly the year that it was created.

So, like I said, the first — this is the first year that we're — that new technology codes are being created, so all the codes created in that year are technology group 1. For example, if next year no new codes are created in the new technology section, then — and they are created in the following year, then we would just skip a group. We wouldn't use the number. We would use the number 2 the next time they are created.

So it doesn't — it doesn't exactly correspond to the year, but it gives you a rough estimate of sort of chronologically which codes are oldest and which codes are newest.

Amanda Foust: OK, thank you.

Rhonda Butler: Um-hum.

Operator: Your next question will come from the line of Nick Vercelli. Nick, your line is open.

Nick Vercelli: Thanks, I had a question on the end-to-end testing. We participated in the group and we received 7 of our 10 claims back, the remittance files. If we wanted to know what happened to the other three or to confirm that they were coming, is there a contact that we can reach out to?

Stacey Shagena: You should have received a resolution report that shows what happened to every one of your claims on, like, an Excel spreadsheet. If you did not receive that, you can reach out to the MAC to get another copy.

Nick Vercelli: OK.

Stacey Shagena: Did you test directly or through your clearinghouse?

Nick Vercelli: Through our clearinghouse.

Stacey Shagena: OK, then the clearinghouse will have a copy of that report.

Nick Vercelli: OK, thank you very much.

Stacey Shagena: Sure.

Operator: Your next question comes from the line of Susan LaPadula.

Susan LaPadula: Hi, good morning. Thank you for holding this conference. I work in the skilled nursing facility part of the business. And I wonder, we submit claims for Part A and for Part B, skilled nursing bills and inpatient claims for Part A. Will we need the X codes on these claims?

Pat Brooks: This is Pat Brooks. If you are currently not using ICD-9-CM procedure codes, then you will not use ICD-10-PCS codes. The ICD-10-PCS codes are only used for hospital inpatient admission reporting. They are not used for other settings, so we didn't change the reporting practices. So if you're currently using CPT codes, you'll continue using CPT codes, and you will never user X codes because they're part of ICD-10-PCS.

Susan LaPadula: Thank you Pat. I have a second question, which is some clarity. If we imagine that we are now in the month of November and ICD-10 has taken effect, and we have a claim to submit in November for a previous month, for example, September, would the September claim be coded in ICD-9 and an October claim coded in ICD-10?

Pat Brooks: Let me state again what Sarah said earlier. The coding system you pick is based on the date of service. See a patient in September, you'll code ICD-9-CM. Beginning on October 1st, 2015, if you have a patient encounter on that day or later and you're billing for a service on October 1st, 2015, or later, you use ICD-10. It has nothing to do with when you submit the bill and everything to do with the date of the encounter.

Leah Nguyen: Thank you.

Susan LaPadula: Thank you Pat.

Pat Brooks: You're welcome.

Operator: Your next question will come from the line of Josh Edwards.

Josh Edwards: Yes, my name is Josh Edwards, I'm from the University of Washington Medical Center in Seattle, Washington. Kind of a followup call to — or question regarding end-to-end testing. We also participated through a clearinghouse for end-to-end testing, and we got back all our ERAs, which we posted into our system. One thing I'd like to be able to do though is confirm our testing results to make sure the payments were accurate. Is there a way to do that? I'm reading SC1501, it looks like the ERAs is based on current year pricing. I'm wondering if we can use the 2014 or 2015 PC Pricer to validate testing results?

Stacey Shagena: Yes, that's exactly correct. That's how you should be validating your testing results. Since we're pricing them on current year, you can compare it to a similar or the same code that would group to the same ICD-9 grouping, and you'd be able to tell if your payment is correct.

Josh Edwards: Is there a particular version that I should be using, would that be 2014 or the newer release 2015?

Sarah Shirey: This is Sarah in Provider Billing. You should use the FY 2015.

Josh Edwards: 2015, thank you very much, I appreciate that.

Operator: Your next question comes from the line of Crystal Hendren.

Crystal Hendren: Hi, this is Crystal Hendren. Thank you. And actually, I think you've addressed the question I have, it was regarding the kind of the rebilling. If we had a claim in September and we had to do some changes to it, would we code in ICD-9 or ICD-10? And based on your answer, I would imagine it's ultimately on the date of service. And so if it was prior to October 1st, we would still be able to use the ICD 9 code and it'd be accepted.

Sarah Shirey: That's correct.

Crystal Hendren: That's correct. Is that correct?

Sarah Shirey: That's correct.

Crystal Hendren: OK. OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Faye Marshall.

Faye Marshall: Yes, hi, my name is Faye Marshall and I code for Eye Health Partners of Middle Tennessee. And I believe this question was asked earlier, but I didn't really hear. I heard you all giving references — resources of where to find information. But could you tell me what – how would we benefit doing the acknowledgment testing? I didn't understand what the whole process was from the beginning to the end.

Stacey Shagena: Acknowledgment testing will show that you can submit an ICD-10 claim and have it accepted by Medicare. So it doesn't produce a remittance or process all the way through the edits, but you will get an acknowledgment that your claim will be accepted so that you know that at least the format of your claim is correct when you come — when it comes to, you know, October 1st.

You can find additional information on the — at the Med Learn Matters Article MM8858, which refers to acknowledgment testing. Additional information specific to you would be on your MAC's website. You know, on their EDI page.

Leah Nguyen: And again for the MLN Matters articles on ICD-10, if you want to click on the link on slide 47, the article that Stacey is referencing is in the ICD Testing Resources and Results section.

Faye Marshall: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Diane Adrignola.

Diane Adrignola: Hi, I was wondering, with that knee sensor, are we supposed to then code the knee sensor and the total knee replacement or just the knee sensor?

Pat Brooks: This is Pat Brooks. You do just like you do today. If they use a knee sensor, that's what you're capturing with the X code. If they do a knee replacement, then you code that. That's a separate concept, so you code what's done with the knee replacement. And this code would be something that describes that they used this during the surgery.

So, if I could just add one other clarification, I misspoke earlier during the call. There are a total of 50 new eye codes created this year with 36 in the Med/Surg and 14 in the new tech. area.

Diane Adrignola: OK, But I'm still confused. So, that sensor, though, is taking the place of a total knee replacement, so if I …

Pat Brooks: No, it's not actually. If you want to read and actually see a wonderful video on how these works, if you'll look at the link I provided for the March 2015 Coordination and Maintenance Committee, there was a great presentation describing in what this sensor does. And basically today, most physicians replace the knee and then they use their judgment or whatever measurement and they try to make sure they've got all these things — everything lined up well.

This sensor is said to improve the ability to make sure that when you put in these devices, that they're all lined up correctly. Now measuring and lining things up correctly is not something we normally capture in ICD-9 or ICD-10-PCS. But as Rhonda said, there was a request – if it improves outcome or not, and so in order to be able to track it should physicians in your hospital decide to use this or not, then you have an X code that you can report if it's used. If it's not used, you will never report this.

Diane Adrignola: OK, thank you.

Operator: Your next question comes from the line of Yvonne Hill.

Yvonne Hill: Hi, yes. I think we pretty much got our question answered. Somebody else — somebody else actually asked the question ahead of us. We were asking about — we were curious about a transition question, but someone answered it. So we got our answer.

Leah Nguyen: Thank you.

Operator: Thank you. Your next question will come from the line of Lori Robinson. Lori, your line is open.

Your next question will come from the line of Amy Austin.

Amy Austin: Hello, I had a — I was just wondering if we are supposed to be using these codes. I have about 15 physicians and we staff both of the intensive care units at our local hospital, but we don't bill Medicare Part A, so I'm not really quite sure if these would even affect us at all.

Pat Brooks: This is Pat Brooks. If you're billing for your physicians for their services, you will never use ICD-10. You will continue using CPT codes to show physician services in their office as well as physician services in inpatient hospital.

The only people that will use ICD-10-PCS are hospitals reporting hospital claims and for services, so physician offices will have to learn ICD-10-PCS or the X code part of it.

Amy Austin: OK, great. Thank you.

Operator: Your next question comes from the line of Diane Petersen.

Diane Petersen: Hi, good afternoon. This is Diane Petersen, and the question I have is, I do home health and hospice. So my — the codes that I'm going to be using there, you know, like for an episode, and if my episode starts before October, like September was an example I heard, how is that going to affect with episodic billing?

Sarah Shirey: Hi, we actually have a great article on home health episodes that span the October 1st, 2015, date, and you can find that — a link to those articles on slide 46. The specific article is Special Edition SE1410.

Diane Petersen: I'm looking at page 46 and that's on here?

Leah Nguyen: Actually, slide 47.

Sarah Shirey: Sorry.

Leah Nguyen: This is a link for Medicare Fee-For-Service provider resources and then it will be listed in the MLN Matters Articles section.

Diane Petersen: Hang on, MLN Matters articles?

Leah Nguyen: Yes.

Diane Petersen: Thank you so much. I appreciate your time.

Sarah Shirey: Oh, you're welcome.

Diane Peterson: Bye.

Leah Nguyen: Thank you.

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question will come from the line of Lauren Bellenie.

Lauren Bellenie: Hi there, my name is Lauren and I work with a mental health provider. I was wondering if you guys have any resources regarding the DSM transition that is occurring around the same time as ICD-10 transition. We've been looking for some sort of crosswalk, and I'm just wondering if you know of any other available resources regarding it?

Leah Nguyen: We'll have Pat look into that. Do you want to – if you want, you can email the questions to our resource box, which is listed on slide 51, and I can go ahead and research that for you.

Lauren Bellenie: OK, great. OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Kathy Hurdley.

Kathy Hurdley: Hello. My question is in regards to specific diagnosis codes. A lot of times I do billing for infectious disease. And sometimes they code it as, like, a Septicemia or a Cellulitis; however, they don't actually identify the bacteria until after a culture has come back. Would I have to wait till I get the actual disease that is in that culture or am I able to use an unspecified?

Pat Brooks: This is Pat Brooks. Nothing about ICD-10 makes you change your reporting behavior. So right now, when you report the patient has Septicemia and you're a physician office and you bill because you don't know the type, you go ahead and bill it and you – because that's all you know at the time you bill. You do not have to do additional testing or wait for testing results to come back to bill.

If you see that patient on a next encounter and you know more, you've got the results back, then you could choose a more precise code. But basically, code what you know at the time of encounter and that may be only a symptom or sign or may be a diagnosis without really detailed specificity.

But ICD-10 allows you to code very detailed if you know what you know. But if you don't have the information yet, then there are unspecified codes that you can use and be comfortable in doing so. So continue to do just what you're doing now.

Kathy Hurdley: Well, thank you very much.

Operator: Your next question will come from the line of Tracy Parker.

Tracy Parker: Thank you. My question is, are there any recommended resources that help to identify specific claim adjustment reasons or remarked reason codes related to ICD-10?

Leah Nguyen: We can look into that. Do you want to email it to the address we have listed on slide 51?

Tracy Parker: Yes, thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Lindsey Fine.

Lindsey Fine: I just had a question on the inpatient. Can you still use ICD-9 procedure codes in combination with the new ICD-10 X codes?

Pat Brooks: This is Pat Brooks and, no. I think Denesecia wrote down the word "no dual coding or submitting." And what we mean by that is, right now, for services through September 30th, 2015, you can report only ICD-9 codes. You can't send in an ICD-10 code with it. All for services that occur on or after October 1st, 2015, you can only use ICD-10 code. You cannot send an ICD-9 code along. There's no dual coding. There's a very firm cutoff date, and that date is determined by the date of service.

Lindsey Fine: So all the procedure codes that are currently there are also crop10 codes plus the X codes were added?

Pat Brooks: I don't fully understand what your point — the question is, but let me try it this way. On October 1, 2015, we'll implement ICD-10-PCS and ICD-10-CM. All those new codes, there'll be a certain small number, only 14 that are X codes. So if you are an inpatient admission occurring — or discharged, actually, is the way we do inpatient coding. If there's a discharge that occurs on or after October 1, 2015, one would code that using the ICD-10 code coding system. You would use your index like you do now. You'd arrive at the correct code.

Lindsey Fine: OK. And then to follow up to somebody else's, they asked if there was a reference for CARCs/RARCs and you told them to email. How would somebody else get

the answer to that question, too, if they're going to email the answer because that would be something I'd be interested in also.

Leah Nguyen: Hello. Actually, if you want to just send an email about that as well, that you're also interested in that answer, that way I can make sure I get it out for you.

Lindsey Fine: OK, perfect. Thank you.

Leah Nguyen: Thank you.

Operator*:* Your next question will come from the line of Joy Lera.

Joy Lera: Hi, thank you for having this training. Our question is a little bit more — is there an ICD-10 training specific for long-term care facilities?

Denesecia Green: Hi, this is Denesecia. We don't have one specifically for long-term care at this time, …

Joy Lera: OK.

Denesecia Green: … but certainly we can start to put together some material that speaks to your community.

Joy Lera: Yes, because we have a question. For example, the resident admits to SNF from an acute on IV antibiotics, and so can we use the X code for that?

Denesecia Green: What I would suggest is that if you send in a request for some additional training to share your interest, I think we can pull together at least some fact sheets or something that addresses your question.

Joy Lera: OK.

Pat Brooks: And this is Pat Brooks. This is Pat Brooks, I'd like to suggest another thing. If you have a specific coding question, and it's a real question — you have a medical record — what you can do is the American Hospital Association has a central office for ICD-10. They will respond to your coding question. You will send them a copy of the medical record and you will say, how do I code this, and maybe it's a procedure or the administration of this drug or whatever. And then they will go through and tell if you have the correct code either for the diagnosis or procedure codes. So if that helps.

Joy Lera: OK, thank you.

Pat Brooks: Hypothetical questions, they won't respond to those, but if you have a real one that you want to know how to handle under ICD-10, they will answer them.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Linda Holtzman.

Linda Holtzman: Hi, thanks very much for holding this. I have a question about section X. There's a major concern in industry that payers may conflate ICD-10-PCS Section X codes with category 3 CPT codes. CPT category 3 codes are, you know, emerging technologies without major evidence in the literature, so they're often blanket and noncovered. Whereas, ICD-10-PCS Section X codes already have to be FDA approved and already have to demonstrate that they're actually superior to existing technologies.

So I'm wondering if CMS will be issuing materials clearly making this distinction and clarifying that the ICD-10-PCS Section X codes are in no way category 3 CPT codes — that they're not experimental, they're not unproven, and that there is a very clear distinction between these two types of codes.

Pat Brooks: Thank you Linda, this is Pat Brooks. Actually, at the Maintenance Committee meeting, we do talk about all the standards for creating codes in general, and one of them is the X codes and for new technologies, as you point out, is this FDA coverage. The way we at CMS handle whether something is paid or not paid, and all of these are inpatient reporting only, is through our proposed and final rule.

So all new codes, including X codes, you will read about in table 6s, where we'll discuss what the DRG assignment is. So we'll say that this code is an OR, non-OR, and what DRG they go to. So we handle all our payment issues from these codes equally to lead to the body of the book. But as we move forward, we will try to make it clear to the public that these codes — to the other parts of the book, they just happen to be more specific.

The reason for that is, one, to give additional detail, with the details not present in the rest of the book. There are no better or worse than other parts of the book. But anything you can suggest, or if you would like to perhaps write to Coding Clinic at the American Hospital Association and ask for this question to clarifying, you know, are they – what are the X codes? Perhaps, they could have an educational article for hospitals. But it is true that these codes are equal to the other parts of the book. The payment issues are handled just like we do every other one through our more formal rule making.

Leah Nguyen: Thank you.

Linda Holtzman: Thank you.

Operator: Your next question will come from the line of Janet Jordan.

Janet Jordan: Hi, this is Janet Jordan from Aesthetic Eye Associates. I just wanted to know if on the slides that you have presented today, which has been really helpful, if the links from those slides will still be available after the webinar?

Leah Nguyen: Hi, this is Leah, I'm the moderator. Yes, the slides will still be available on the call web page that was referenced in your confirmation email.

Janet Jordan: OK.

Leah Nguyen: And we'll also be pretty soon, probably a video slide show of the call in case anybody wasn't able to attend.

Janet Jordan: Great. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Susan Beever.

Susan Beever: Yes, this is Susan Beever, and I work at Sarah Bush Hospital in Mattoon, Illinois. I think some of the confusion on the PCS X code guideline was that first line on slide 25 that says that these are standalone codes and they're not supplemental codes. And so, I think that was where the question came in about the knee replacement. I think we understand that this is a technique that helps them in the knee replacement, but, I had the same question as to whether this would be an X code by itself and since it includes the knee replacement in the title or if I would have two codes? So you're saying that there would be a regular surgical PCS code for the knee replacement in addition to the X code on — in that instance.

Pat Brooks: That is correct, and I'm sorry if we can't — sometimes it's hard with short words to clarify the issue. What we were trying to clarify here was say, for instance, if you were to administer an anti-infective drug, would you report a code from the administration section, vague one, meaning, you know, general this one and then the specific one from the X code for that drug, and the answer would be no. If you have a precise code, use that.

If there's — something is done at the same time as something else, which is, I guess, what you call this monitoring, the sensing is done at the same time as a knee replacement, then you would code both things done. You'd code the knee replacement and the fact, the separate fact, that they use this monitoring, this sensing device. And as we get more questions, perhaps, it'll become clear. And thank you for bringing up your concern on that word supplemental.

Susan Beever: Thank you.

Leah Nguyen: Thank you.

Rhonda Butler: Pat, if you wouldn't mind, I'll just add to what you said. I understand the confusion, but what you can do as coder — first of all, there's no blanket prohibition that says, you know, if you have an X code, that's the only code that you code for any operative scenario. It's the same principle that we always use in PCS coding.

If there's a separate root operation objective, then – and it meets the criteria for coding more than one PCS code, then of course you would code it. But as Pat said, this is – if you look at the third character root operation, it's monitoring. It's a monitoring section code, and clearly, that is not — that does not cover the fact that the knee was replaced. You can imagine a situation in which they attempted to put in a knee joint and they used this monitoring device, and they ended up not putting in a knee. So absolutely, you would need to code the fact that the knee joint was replaced.

In the example of the Coronary Atherectomy — the Orbital Atherectomy new technology, you know, these more – these X codes that are describing a technique as opposed to the easy ones. Like Pat was saying, you know, that guideline was really supposed to show you the obvious example where if they're infusing a substance, it's not like the ICD-9 sort of adjunct codes where you just have one little piece of information in the X code but you also have to code something else. You know, the adjunct codes that tell you number of vessels or numbers of stents or something like that.

In this case, with Orbital Atherectomy technology, imagine a scenario where they do an Atherectomy using this new technology. They do that first, and then they follow up and do an Angioplasty with a stent. That's a different root operation. You have the Extirpation and then you have a Dilation with a stent. That also would be coded because it's a separate procedure, a separate root operation objective. So those kinds of …

Susan Beever: I appreciate that.

Rhonda Butler: OK.

Susan Beever: And I hope you understand that this – and I and I hope you understand that with this newness coming in and this being a new section, we want to be sure we understand what the guidelines are telling us to do.

Rhonda Butler: Yes, yes, and we appreciate. Sometimes it's difficult, you know, to cover all the aspects of what questions people will anticipate in drafting a guideline. So thank you for your followup question.

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

Operator: OK. Your final question will come from the line of Marianne Schaffer.

Marianne Schaffer: Hi, my question is, are any of these new X codes reimbursement either by driving to a specific DRG? And also, some of the drug codes provided add on payments on the outpatient side, so do we know if any of these X codes are going to do that?

Rhonda Butler: Pat, do you want to address that?

Pat Brooks: Yes, this is Pat Brooks. I'm sorry, I had myself on mute. You will find out about the DRG assignments for all the X codes in the Inpatient Final Rule, which will be published about August 1st. I mentioned earlier, there's a table 6 that describes this. So every new diagnosis and procedure code — that includes the X codes — will have some indication whether they affect the DRG or not.

There are separate parts of the proposed — of the final rule that will address any request for new technology payment. That's a whole separate issue. So for instance, it could have no effect on the DRG and get a new take — and can lead to what is a DRG assignment, just a certain maybe even surgical DRG based on table 6. So you would have – like you do all others, August 1st.

Leah Nguyen: Thank you.

Marianne Schaffer: OK, thank you.

Additional Information

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 51. 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 MNL Connects Provide eNews when these are available.

On slide 53 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 credit should be directed to your organization.

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

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

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