MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Countdown to ICD-10
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

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'd like to welcome you to this MLN Connects National Provider Call on Countdown to ICD-10. MLN Connects Calls are part of the Medicare Learning Network®.

ICD-10 implementation is just 5 weeks away. Today's call includes a presentation from the CMS Acting Administrator, followed by presentation from the American Health Information Management Association and the American Hospital Association, along with updates from CMS subject matter experts. A question-and-answer session will follow the presentation.

You should have received a link to the presentation materials for today's call in previous registration emails. If you have not already done so, please download the slide presentation and testing results from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the August 27th call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the 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 would like to turn the call over to CMS Acting Administrator Andy Slavitt.

Presentation

Andy Slavitt: Thank you, and thank you all for joining the National Provider Call on the transition to ICD-10. First off, I want to thank you for the care you provide to Medicare and Medicaid beneficiaries every day. We both have the same aim of making sure that our beneficiaries receive the highest quality care, and our aim at CMS is to support you in the most efficient ways possible.

We're aware that the health care system is going through a period of significant changes — new payment approaches, new technology, new measurements, and, of course, ICD-10. Operationally, these changes impact us, and they impact you.

ICD-10, while we've seen it coming for a while, finally is almost here. ICD-10 has the potential to create many improvements in our public health system and set the stage for improved patient care and public health surveillance across the country, leading to better identification of illnesses and earlier warning signs of epidemics and pandemics, such as Ebola, and improved coordination of your patients' care across providers.

After years of investment by the health care community, we are nearing the ICD-10 finish line. The October 1st transition date is only 34 days away. To be clear, with this transition, CMS, like many other payers, will not be able to accept ICD-9 codes for dates of service after September 30, 2015, nor will we be able to accept claims with both ICD-9 and ICD-10 codes.

As the date of the transition approaches, I would like to emphasize three points in my conversation with you today, which are critical for all of our success:

- Preparation,
- Assistance, and
- Collaboration.

As with everything, with proper preparation, this transition can be highly successful, and without preparation, there will be challenges. The good news is, even for medical practices that haven't done much, there is still time to prepare.

On our end, CMS has been doing exactly that — prepare, prepare, prepare. Or as the surgeons like to say, measure twice, cut once. Our team has been making preparations in a number of areas:

- First, converting our systems from ICD-9 to ICD-10; that sounds obvious;

- Second, helping the care providers in the community prepare by offering an array of resources; and

- Third, doing a whole lot of testing and inviting the provider community to test with us.

Though we've also been closely monitoring State Medicaid plan readiness and helping others prepare, our role is to be ready, just like yours.

That brings me to my second point, assistance. To that end, we offer many free resources to assist you in your readiness efforts. On our website, cms.gov/icd10, you can access easy-to-use tools. Let me highlight several.

First, to jumpstart your efforts, begin with the ICD-10 Quick Start Guide. Another set of valuable planning tools is what we call The Road to 10, which allows physicians and other providers to build customized ICD-10 action plans and includes primers for clinical documentation, clinical scenarios, and resources tailored by specialty.

Third, there's also a wealth of Medicare Learning Network products, including videos, that are available on the CMS YouTube page. So I encourage everyone to take advantage of the acknowledgement testing that is available to all Medicare submitters through September 30th. This testing will confirm whether you can successfully submit claims with ICD-10 codes to Medicare.

The third area is collaboration. Our partnerships are critical to the successful implementation of ICD-10 across the industry. We have met and listened to feedback from over 400 organizations over the past many months. I would like to thank everybody who has provided CMS with important feedback and those who has worked tirelessly with the provider community. There are a world of places that can provide you help and answer questions.

I would specifically like to thank the American Medical Association, American Hospital Association, the State medical societies, and other advocacy groups for working with my team to help us develop policies that are responsive to your needs. Also, having representatives from AHIMA, American Health Information Management Association, and the American Hospital Association on this call and past National Provider Calls discuss ICD-10 coding has been fundamental to readiness efforts.

If you ever wonder whether your advocates in Washington communicate well with us about the issues that matter to you, they do. Let me spend a final few minutes on some important ways we plan to manage this transition after October 1. We have set up and are now staffing a new CMS ICD-10 coordination center, located in Baltimore, Maryland. It will begin operations at the end of September and be responsible for managing and triaging issues and ensuring timely communications with all of you and with me on how we're doing.

I'm also very pleased to announce on this call that we are naming today an official ICD-10 Ombudsman. I'm pleased to introduce Dr. William Rogers, who will be filling that role. Dr. Rogers, a practicing emergency room physician, is known to many of you already. Since 2002, he has been the Director of the Agency's Physicians Regulatory Improvement Team, assisting physicians, other practitioners, and medical societies in identifying and simplifying Medicare policies and regulations. He chairs regular sessions with provider and health care associations to disseminate information from CMS and

answer industry questions. In addition to his CMS and emergency room work, Dr. Rogers is also a colonel in the United States Air Force, serving as the State Air Surgeon to the Joint Force Headquarters. In fact, he recently returned from a military tour in Germany.

His role as ombudsman will be to be a one-stop shop for you with questions and concerns and to be your internal advocate inside CMS. If you take something away from this call, in addition to the imperative to be ready for October 1, it is how to reach Dr. Rogers's ombudsman office. His email address will be icd10_ombudsman@cms.hhs.gov.

I have followed our progress on this journey weekly since I joined CMS. As with anything of this magnitude, even with all the planning, there will be bumps and challenges. Our plan — our job is to plan for them, too. I've learned over time that great organizations are even good at dealing with the unexpected. The many people involved in the work here are ready to respond to issues as they arise and with the full resources I've outlined.

I will close where I started. Preparation, assistance, and collaboration are our keys, and I will be paying personal attention to everything that happens between now and after our launch. I am excited about the transition to ICD-10, with ready systems, easy-to-use tools, the dedicated ICD-10 ombudsman.

CMS is committed to working closely with the provider community to make important progress towards modernizing our health care infrastructure. And with that, I will turn the call back over to the moderators.

Leah Nguyen: Thank you Mr. Slavitt. Sue Bowman from the American Health Information Management Association and Nelly Leon-Chisen from the American Hospital Association have also joined us today to talk about preparing for ICD-10 coding and documentation. I will now turn the call over to Sue Bowman.

Preparing for ICD-10 Coding and Implementation

Sue Bowman: Thank you Leah. Nelly and I will be reviewing some of the basics regarding the transition and coding and documentation requirements.

So, starting with slide 5. ICD-10-CM, the new diagnosis coding system, will be used by all providers in every health care setting. So in a nutshell, if you work at an organization that currently is required to report ICD-9-CM diagnosis codes, then you will be transitioning to ICD-10-CM diagnosis codes on October 1st.

On slide 6, ICD-10-PCS, the new Procedure Coding System, will be used only for hospital claims for inpatient hospital procedures. It will not be used on physician claims, even physician claims for inpatient visits. So there is no impact on the use of the CPT and HCPCS code. CPT and HCPCS will continue to be used for physician and outpatient

services, including physician visits to inpatients. That will not change as part of the transition to ICD-10.

If you are currently required to report ICD-9 procedure codes, then you will be transitioning to ICD-10-PCS on October 1st, 2015. If you do not currently report ICD-9 procedure codes, then your procedure coding system that you're currently using will not be changing.

On slide 8, the determination of which code set to use is driven by the date of service, not the billing date. The date of service is defined as — is the date of service for outpatient and physician reporting, the actual date of the service. And for inpatient facility reporting, the date of service is defined as the date of discharge.

So as Mr. Slavitt indicated, claims for dates of service on and after October 1st, 2015, must be coded in ICD-10, and claims for dates of service prior to October 1st must be coded in ICD-9.

ICD-10 Coding Examples

So here's an example on slide 9. A patient visit to a physician office on September 30th will be coded in ICD-9. A patient visit to a physician office on October 1st will be coded in ICD-10. The claim submission date is irrelevant in determining which code set to use. If a claim is submitted after October 1st for a date of service prior to October 1st, ICD-9 codes and not ICD-10 codes should be reported.

And again, just as a reminder, for inpatient facility reporting, date of service is defined as the date of discharge. So, for a patient admitted to the hospital on September 27th and discharged on October 2nd, which coding system would the hospital use on its claim? If you're thinking ICD-10, you're correct. Since the discharge date is after October 1st, the hospital claim would be coded with ICD-10 codes.

On slide 10, no claim can contain both ICD-9 and ICD-10 codes. CMS has provided guidance on how to handle claims that span the October 1st transition date, and they will be addressing these claims as well as episode coding in more detail later in today's presentation. There will be no dual code reporting, meaning that any claims for dates of service after October 1st, 2015, that contain ICD-9 codes will be rejected.

So on slide 11, how will the transition impact Medicare payment? Well, for physician claims in general, the MACs will use ICD-10-CM codes to determine coverage but not to determine the amount that CMS will pay for furnished services. That — the payment amount for physician services will continue to be driven by CPT and HCPCS codes. For hospital inpatient claims, the MACs will use ICD-10-CM and ICD-10-PCS codes to assign the patient discharges to the appropriate ICD-10-MS-DRGs.

On slide 12, the good news is, there is no change in the process of assigning a diagnosis code in ICD-10-CM, and we'll be showing you a couple of examples a little later. You look up the diagnostic term in the alphabetic index, and then you verify the correct code number in the tabular, just as you currently do with ICD-9.

To be valid, ICD-10-CM diagnosis code must be coded to the full number of characters required for that code. And on the CMS website, there's a complete list of all of the ICD-10-CM valid codes and the code titles, which should help providers who are unsure as to whether an additional 4^{th}, 5^{th}, 6^{th}, or 7^{th} character is needed for that code to be valid. And the link is shown there on slide 12 to that list.

So, on slide 13, let's look at a few examples. In ICD-10-CM, all of the codes are not the same length. So some examples of some invalid codes are the codes listed there under the first bullet for S02. All of the codes in S02 require seven characters in order to be valid. So the codes listed there on the screen — S02, S02.60 — are not considered valid codes. It's important to keep in mind that only codes in a few chapters require seven characters. And these chapters are the obstetrics, injury, musculoskeletal, and external cause codes — external cause chapters.

The other chapters do not necessarily have 7^{th} characters generally. So I've gotten some questions before about what is the appropriate 7^{th} character for a pneumonia patient or a depression patient, and there is no 7^{th} character for those codes. So you just have to keep in mind that those seven characters don't apply to all of the chapters.

In the last bullet point on slide 13, here's some examples of some invalid and some valid codes. So E10 is an invalid code because it has more applicable characters that you have to assign in order for the code to be valid. E10.2 is also invalid, but E10.21 is a valid code. So you really need to pay close attention, because as I mentioned earlier, all of the codes are not the same length in order to be valid. For example, I10 is a valid code. It does not have any more characters associated with it.

On slide 14, many coding, billing, and claims editing programs have flags to identify invalid codes to help you make sure that you don't inadvertently report an invalid code. Many code book publishers also help to identify invalid codes, using a variety of formats, such as color coding, flags, symbols, or hyphens. So generally, whether you're using an electronic tool or a hard copy book or your claims submission program, there's a variety of ways that help identify for you that the code is invalid and requires some more characters in order to be considered a valid code.

In ICD-10-CM, just as in ICD-9-CM, there are unspecified codes to use when the documentation does not support a more specific code. Obviously, whenever possible, when the clinical information is available, it's best to have the most specific documentation in order to get the best health care data about the patient encounter. But there are times when that documentation just isn't available or the clinician himself

doesn't know any more yet about the patient's disease process because that is still being explored. So unspecified codes should still be used when they're appropriate. They have acceptable, even necessary uses. And that's an important part to keep in mind. And that's just the way it is today.

There's been a lot of misinformation that, because ICD-10-CM has more specificity, that you have to always use that greater specificity. But there are very good occasions when you just aren't able to do that, and the unspecified code is the correct code. It would not be appropriate to select a specific code that's not supported by the medical record documentation or conduct medically unnecessary testing on the patient in order to determine a more specific code. And this information about the use of unspecified codes is part of the ICD-10-CM official guidelines for coding and reporting, which all HIPAA-covered entities must comply with. It's part of the HIPAA ICD-10 standard code set.

On slide 17, here are some common examples of unspecified codes that are often appropriate. Anemia when you don't know any more information about the type of anemia, and there is the ICD-9 and ICD-10 codes for unspecified anemia. Abdominal pain, sometimes that's all you know. Stroke, you may not have more information about the type or location of the stroke. Angina and COPD are other common examples of common unspecified codes.

So on slide 18, here is an unspecified code example. A patient is seen by the family practitioner for hay fever. The patient also has Hodgkin's lymphoma, which is being treated by another physician, and the family practitioner doesn't have more specific information regarding the type and site of the Hodgkin's lymphoma. It's perfectly appropriate to use the C81.90 for the unspecified Hodgkin's lymphoma because family practitioner just doesn't have any more information, but he still wants to capture the fact that the patient does have Hodgkin's lymphoma. But it's not the focus of the care he's providing to the patient or the focus of that particular encounter. So this would be an example of an appropriate use of an unspecified code.

Now let's walk through a couple of coding examples so you can see how easy it is to assign a code and how similar it is to the ICD-9 coding process. So the code you get to at the end is a little bit different, but the process is very much the same.

So in slide 19, let's look at diabetes. Look up diabetes in the alphabetic index. And in this particular case, we're saying the patient has type 2 diabetes, so you look at the subentry, type 2. It says E11.9.

On slide 20, it shows you that when you go to the tabular list, you look up E11.9, there was no mention of any particular complications or manifestations with this patient's diabetes, so the code is E11.9 type 2 diabetes without complications. It's just that simple.

Now I will turn it over to Nelly Leon-Chisen, who is going to walk us through another ICD-10 coding example.

Nelly Leon-Chisen: Thank you Sue. Hello everyone. And we're now on slide 21. And we will do one more ICD-10-CM coding example, just to show you that the same steps that Sue took to assign the code for diabetes can be used for any diagnosis you want to code.

So we're going to code carpal tunnel syndrome, right side. Step 1 is to look up the term in the alphabetic index, just like in a dictionary, we look at the main term, syndrome, with the subterm, carpal tunnel, and we get G56.0 and a dash. Now, the dash indicates that an additional character is required to complete the code.

On the next slide, you can see step 2, which is to verify the code in the tabular list. We see G56.0, carpal tunnel syndrome, but we're not done just yet. The code is invalid because we're missing characters. Because we know that this is carpal tunnel syndrome of the right side, we see the options available, and the correct code is G56.01 carpal tunnel syndrome, right upper limb. And if we didn't know what side it was, the unspecified code would be G56.00 for unspecified limb.

On slide 23, let's talk about preparation. Mr. Slavitt talked about that, but I want to kind of get into it a little bit more. It's important to prepare now. There is still time to prepare, but please don't wait. You need to get started. There are five simple key steps that are outlined in detail on the CMS ICD-10 Quick Start Guide that was mentioned earlier. It's an excellent resource. And actually, I think it's the best thing I have seen for physician practices to get ready. In fact, since CMS released the Quick Start Guide, I make sure it gets distributed at all the physician presentations that I do on ICD-10. It's very simple, very straightforward.

The first step is to make a plan and access to ICD-10 codes. The second step is to train staff. Clinical staff would focus on documentation, and the coding or administrative staff would focus on the ICD-10 fundamentals. Identify the top codes your practice uses. Don't worry so much about the number of codes that there are because you're not going to be using all of them. CMS has excellent resources, again with clinical concepts and the corresponding ICD-10-CM codes for many different specialties. Please be sure to take a look at that.

Step 3 is to update your processes. And this includes your hard copy, as well as electronic forms and any superbills or encounter forms that you may have. Step 4 is to talk to your vendors and health plans. Ask about readiness, including any software changes and testing opportunities. And step 5 is to test systems and processes both inside your practice, your hospital, or wherever setting you're in, and test with your trading partners to verify that you can actually generate claims.

So on slide 24, let's talk about how to obtain a code book. You'll see that there is a free ICD-10-CM code set version available from the CDC. There are also a variety of hard copy books from several publishers, as well as other associated tools with helpful hints that are available from commercial vendors. These are available on paper or electronic, and there are even some mobile apps available.

Documentation for ICD-10

On slide 25, let's discuss the increasing demand for high-quality documentation. There are external forces in the current and future health care environment that demand high-quality clinical documentation. Now these demands are being driven by initiatives such as quality measurement reporting, value-based purchasing, and patient safety. So these demands exist independent of the move to ICD-10, and you may have heard or read about them already. And so, ICD-10 will be helpful to provide the additional information that you document in your records, but the ICD-10 codes can help you put that into a code and distribute them wherever they need to be.

So with or without the transition to ICD-10, expectations for more detailed documentation will continue to grow. If complete information is not captured in a clinical documentation, the result will be incomplete documentation for coding that then can impact revenues through delays, missed revenues, outcome measures that don't clearly or accurately reflect the quality and complexity of the care that is being delivered. So complete and accurate documentation ensures that there is a complete picture of how sick the patient is and what was done for that patient.

On slide 26, let's talk about the link between clinical documentation and ICD-10. One way to look at it is that this increased specificity of ICD-10 codes requires more detailed clinical documentation, and that can be at different levels. For example, it would be as simple as identifying which side was affected. Is it right, left, bilateral, or unspecified? Another way to look at it is that if your documentation is already in pretty good shape, there may only be a need to tweak it a little bit in a few areas, but the increased specificity of the codes will actually better reflect the differences in severity in the patients treated. So it's important to understand what the differences are.

ICD-10-PCS Coding

As Sue mentioned earlier, there is also an ICD-10 Procedure Coding System, ICD-10-PCS, that hospitals will need to implement for the reporting of inpatient procedures. This applies only to hospitals and not to physicians or other providers. And this is important, because sometimes we get questions because it can be confusing because you may not even realize that physicians use one coding system and hospitals use a different one for our inpatients.

So ICD-10-PCS applies only to hospitals and not to physicians or other providers, even if the physician has performed the procedure in a hospital on an inpatient. The

ICD-10-PCS coding system is much more specific than the ICD-9-CM procedure codes that hospital coding professionals use today and will require coders to understand in greater detail the procedures performed. However, physicians are not required to document those procedures using the exact same terms that are listed in the ICD-10-PCS classification.

According to the official coding guidelines for ICD-10-PCS, and this is similar to the diagnosis guidelines that Sue mentioned earlier that are HIPAA standard. So we have another set of guidelines that are for procedures. These guidelines say that it is the coder's responsibility to determine what the documentation in the medical record equates to in the ICD-10-PCS definition. The coder is not required to ask a physician for additional information when the correlation between the documentation and the defined ICD-10-PCS terms is clear.

However, I would be remiss if I did not put in a plea on behalf of the hospital coders. We may need the help of our physicians to understand the objective of the procedure in order to select the appropriate values, especially as we are also learning a new coding system and we're trying to become more proficient in using these new terms. So please, be patient with us as we ask you questions that may be very obvious to you as a physician but that our coders may need help translating.

There are many more ICD-10-PCS procedure codes, and we will need to know, is it the right side, the left side, bilateral, just like you do need that for the diagnoses but also the more specific anatomic site that was operated on, like what muscle or vein or artery the procedure was performed on.

On slide 27, let's talk about assessing current documentation practices. This is very important, and it can be done by targeting your most common diagnoses, for example, coding a sample of your records using ICD-10 and identifying any documentation gaps. Then you need to work on resolving those gaps. If you have an electronic record, leverage the technology to capture documentation at the point of care using templates or prompts.

Forms or templates should be modified to resolve documentation gaps, along with education and perhaps workflow or operational process changes. Perhaps it's something simple, like adding the more detailed information from the medical record that you are already documenting on to your billing form or making sure if, in a physician practice, the medical record is not made available to the biller of the coder, perhaps you should change your processes to make sure that the person assigning the codes has the information available in your record.

Resources for Coding Questions

Once you learn how to code, you're not alone, as we see on slide 28. The American Hospital Association has supported the AHA Central Office coding clearinghouse service

since 1963. At that time, only hospitals were working with ICD codes, so it was natural to create the clearinghouse to support our members. The clearinghouse was established by a memorandum of understanding with the Department of Health and Human Services to collaborate and provide free assistance with ICD-9-CM advice.

Of course, since then many more providers are reporting diagnosis codes. In order to support the fields' preparation for ICD-10 implementation, we began providing both ICD-10-CM and ICD-10-PCS for the hospital inpatient services. We have provided advice in these codes since — beginning in 2012, at the same time that we continue to provide ICD-9-CM advice.

But at the beginning of 2014, we switched to completely and solely providing ICD-10-CM and ICD-10-PCS advice and education. However, I want to emphasize that our service cannot possibly replace learning how to code. You still need to do that. What we do provide is a clearinghouse service that triages the questions that we get, and we provide direct advice based on established, published resources. Anything that is outside of that, that needs additional clarification or has not been addressed before, it's addressed or referred to the Coding Clinic Editorial Advisor Board, or EAB, for discussion and development of a consensus opinion.

On slide 29, we have information on how to submit a coding question. Questions can be submitted via our online service to www.codingclinicadvisor.com. Again, this is a free service, so we ask users to become familiar with the service and review the Frequently Asked Questions section for details. The same process was used for ICD-9-CM questions. So be sure to formulate an actual coding question, and please don't just ask us to code your entire superbill, or send us an entire record and ask us to code it, or to validate your code assignment, or just ask us what is the code for xyz disease or xyz procedure. And by the way, we can only address specific coding problems that are submitted with supporting medical records documentation.

Along with your question, specify whether the question refers to a certain setting—for example, the skilled nursing facility, home health, or a particular type of provider, perhaps a physical therapist, occupational therapist, and so on. We cannot answer questions on payments or coverage issues or on the General Equivalence Maps, or the GEMs. Also, we regret that we are not able to support requests for ICD-10-PCS coding advice related to hospital reporting of outpatient procedures. To reiterate, ICS-10-PCS is the HIPAA standard for inpatient hospital procedure coding only.

On the next slide, let's talk about Coding Clinic, the AHA Coding Clinic publication. It's a quarterly publication, and it provides practical examples from our clearinghouse service. For over 30 years, we have provided ICD-9-CM advice, and we provide real life application of the classification rules and guidelines based on the questions and documentation sent to us by providers. Since 2012, we have fielded ICD-10-CM and

ICD-10-PCS questions from providers who were actually practicing how to code with ICD-10.

So Coding Clinic has been helping to fill in those knowledge gaps on code selection identified by these early adopters so that all providers get to share in the benefits from the advice where a consensus opinion has been achieved. Coding Clinic is available on an annual paid subscription basis directly from the AHA, or it can be obtained electronically through all the major encoder software programs which license our content.

We also offer free coding webinars, and these are available live as well as on demand on our website, including a couple where we highlighted the best of Coding Clinic. For example, one of our more popular programs was a webinar back in March which provided the highlights of advice and clarifications as well as case scenarios on how to apply the 7th character for ICD-10-CM for injury and external cause and morbidity codes. Those scenarios were developed based on questions received by our office and in collaboration with the physician members on the Editorial Advisory Board. Our webinars also qualify for continuing education hours for both AAPC as well as AHIMA.

On slide 31, you can see the organizations that make up the Coding Clinic Editorial Advisory Board, which develops the advice that is published in Coding Clinic. And you can see that it consists of the AHA, AHIMA, as well as CMS and the CDC's National Center for Health Statistics. These last two agencies are the official maintainers of the ICD-10 code sets. Clinical guidance is provided by physicians representing the American Medical Association, American College of Physicians, American College of Surgeons, and the American Academy of Pediatrics. In addition, we also work with other physician specialties on an ad hoc basis, along with coding experts.

In summary, ICD-10-CM diagnosis coding will apply to all health care providers for services effective October 1st, 2015. Again, just to recap, unspecified codes have acceptable and even necessary uses. In fact, correct coding means to code to the level of specificity known for that encounter. And again, just to clarify, there is a companion Procedure Coding System called ICD-10-PCS, which applies only to hospitals reporting inpatient procedures. Providers currently reporting CPT, HCPCS for their services will see no change in using those codes. They will only need to change their diagnosis codes.

There are many excellent resources, again, many of them free or at minimal cost, available from many organizations, including CMS, AHIMA, and the AHA. And you can see them listed on slides 33 to 36. Thank you for your attention, and then I will now turn you back to Leah.

Keypad Polling

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

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Leah Nguyen.

Presentation Continued

Leah Nguyen: Thank you Kalia. I will now turn the call over to Felicia Rowe from the Provider Billing Group for a presentation on Medicare Fee-for-Service claims processing, billing, and reporting guidelines.

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

Felicia Rowe: Thank you Leah. Good afternoon everyone. Since the last time we presented at the November 2014 National call, not much has changed in terms of the overall readiness of the Medicare Fee-for-Service claims processing system. Medicare's Fee-for-Service claims system is ready to accept ICD-10 diagnosis and procedure codes. For those of you who are joining us for the first time, I'll briefly recap our process for preparing the Medicare Fee-for-Service claims system for the transition to ICD-10, as well as cover some of the basic guidance for submitting claims.

So starting with slide 38, all of our behind-the-scenes work to prepare our claims system was completed by October 1st of 2013, which gave CMS 2 years to conduct ongoing internal testing of the Medicare Fee-for-Service claims system and conduct an external testing, both of which will be discussed in further detail later in this presentation. Prior to installing changes for ICD-10, CMS completed the transition to version 5010 for all electronic HIPAA-compliant claim transactions, which included field size expansion to support the transition to new formats for ICD-10 diagnosis and procedure codes.

Then, in order to prepare for the transition to ICD-10, all of our claims processing systems were scanned for the presence of ICD-9 codes. Each of the ICD-9 scenarios we found was reviewed by various payment policy and claims processing subject matter experts and were ultimately converted to ICD-10. So overall, our behind-the-scenes changes have included conversion of well over 200 individual claims processing edits, updating and reformatting of various system tables and adjudication logic, and updating of all internal files and user screens.

On slide 39, we've highlighted several basic claim submission rules pertaining to the transition to ICD-10. Most importantly, as mentioned earlier in the presentation, ICD-9 codes will no longer be accepted on claims for dates of service on or after October 1st of 2015. ICD-10 codes will not be recognized or accepted on claims for dates of service prior to October 1st. Claims cannot contain both ICD-9 codes and ICD-10 codes. And finally, there will be no dual processing of ICD-9 and ICD-10 after October 1st. We will only accept ICD-10 codes after the transition date.

Claims that do not meet these standards will be returned to provider or returned as unprocessable, depending on the type of claims you submit. So keep in mind that if your claim does not contain the correct code set based on the date of service, or does not contain a valid code from that code set, your claim will be returned to you for correction.

So how do you select the correct code set? Well, in general, for professional/supplier and outpatient hospital claims, ICD-10 diagnosis codes are required on claims which — from dates of service on or after 10/1/2015. For inpatient hospital claims, ICD-10 diagnosis and ICD-10 procedure codes must be used if the discharge or through date of service is on or after 10/1 of 2015. For guidance on submission of other bill types that I haven't mentioned, please refer to the MLN Matters Special Edition Article SE1408. There's a link to that article on slide 41.

On slide 40, you'll see that I've highlighted a few claim types and how to handle those claims that cross over or span the October 1, 2015, transition date. For inpatient claims, with dates of service that span the October 1st date, you will select the appropriate code set based on the through or discharge date on your claim. For outpatient claims — excuse me, outpatient claims must be split such that the dates of service prior to October 1st are billed on a single claim using ICD-9 codes, and all dates of service occurring after — on and after the October 1st transition date will be billed on a separate claim using ICD-10 codes.

Professional and supplier claims, including durable medical equipment, prosthetics, orthotics, and supplies claims, must select the correct code set based on the from date of service on that span-dated claim. So again, please refer to the table in MLN Article SE1408, which gives instructions for selecting the appropriate code set for all Medicare Fee-for-Service claim types.

And finally, on slide 41, I've listed a few educational articles that speak to general processing claims that span the 10/1/15 date targeted to outpatient and home health claims. The Frequently Asked Questions document also contains useful information about handling of certificates of medical necessity, prescriptions, and other physician orders. I'd also like to make our hospital providers aware that version 33 of the FY 2016 ICD-10 MS-DRG Grouper Software and Definitions Manual are now available on the NTIS website at www.ntis.gov.

Thank you all for your time.

Leah Nguyen: Thank you Felicia.

At this time, I will turn the call over to CMS Chief of Staff Dr. Mandy Cohen to discuss the CMS and AMA joint announcement.

CMS and AMA Joint Announcement

Dr. Mandy Cohen: Thanks everyone and thank you Leah. This is Mandy Cohen. I'm going to talk a bit about some of the flexibilities as we transition to ICD-10 on October 1st.

So back in July, CMS and the American Medical Association issued joint guidance in an announcement about flexibilities in the Medicare claims auditing and quality reporting process. The flexibilities are for physicians and other practitioners who are billed under the Part B Physician Fee Schedule.

This call today illustrates, I hope, CMS's commitment to educating the provider communities in how to code correctly ICD-10, and this training should not be perceived to conflict with any of the announced flexibilities. While we encourage coding to the correct level of specificity at all times, the additional flexibilities will assist the medical community as it gains experience with new ICD-10 codes.

As you see on the slide, the flexibilities cover two areas. The first is that for 12 month after implementation of ICD-10. If a valid ICD-10 code is used from the right family of codes, Medicare will process and not audit claims solely for the specificity of the ICD-10 code. So I'll repeat that. Need to have a valid code, but it has to be from the right family, and assuming it's from the right family, Medicare will process that and not audit the claim solely based on specificity. And we'll talk a little bit more about family of codes in a second.

So even with this flexibility, there are some additional caveats to that. All claims for services rendered on or October 1st, again, must have a valid code. If this valid code — if this code on the claim is not valid, it will be rejected before being accepted for claims processing. Again, if it's rejected, you have the opportunity to resubmit the claim with a valid ICD-10 code, but there are certain circumstances where a claim could be denied for a different reason. A claim could be denied because an ICD-10 code is not consistent

within applicable policy. Some of those examples might be something like a Local Coverage Determination or a National Coverage Determination.

So again, even with the flexibility, there are certain circumstances unrelated to the validity of the code and the specificity within the family that they still have to be compliant with. Examples are Local Coverage decisions, National Coverage Determinations. But in all the other circumstances, as long as you have the right family of codes, Medicare will process and not audit the claim solely for the specificity of the ICD-10 code.

The second flexibility relates to the CMS quality programs. And so, for program year 2015, Medicare will not subject physicians or other eligible professionals to the PQRS Value Modifier or Meaningful Use penalties during primary source verification or auditing related specificity of the ICD-10 codes. Again, the eligible professional will have to use a valid code from the correct family of codes.

So let me talk a little bit more about family of codes, since we've mentioned it a few times. So on the next slide we'll talk about families of codes. And it's important to understand what we mean by this term. Family of codes is the same thing as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information about the condition. This slide has an example to illustrate the family of codes concept.

If a patient has Crohn's disease, the appropriate family of codes is category K50. Provider must select a valid code from the K50 family. As long as the selected code is in the K50 family, the audit flexibility applies. There are many valid codes within the K50 family. Again, we'd encourage everyone to get to the level — the most level specificity possible, but as long as they bill for a code within the K50 family for a Crohn's disease patient, as listed here on the slide, audit flexibility applies.

CMS has published some clarifying FAQs on this, on the ICD-10 website, on the cms.gov/icd10 website about these flexibilities, including the explanation of what is a valid code, what is a family of codes. If you have additional questions about these flexibilities, you can send it to the address listed on slide 57, include the word flexibilities in the subject line, it helps us triage this better. But, again, we're hoping that these flexibilities allow for physicians and other providers to get comfortable with ICD-10 code set as we transition, and we hope that this alleviates some anxiety around the transition itself, and hope to answer any questions to make sure folks know exactly what will happen on October 1st and beyond. With that, I'll turn it back over to our moderator, Leah.

Leah Nguyen: Thank you Dr. Cohen.

Our next presenter is Stacey Shagena from the Medicare Contractor Management Group, presenting on the Medicare Fee-for -Service Testing Plan for ICD-10 Success.

The Testing Plan for ICD-10 Success

Stacey Shagena: Thank you Leah.

As we near the implementation date and our testing program is coming to an end, I would like to cover with you what CMS, along with the support of thousands of providers and clearinghouse testers have accomplished this past year or so. And I'd like to review the combined results from our testing efforts.

As you may have heard before, we had implemented a four-pronged testing approach to ICD-10 testing to ensure that all of our systems and all of the external stakeholders will be ready for the ICD-10 transition. This includes an internal testing of CMS claims processing systems, provider-initiated beta testing tools, acknowledgment testing, and end-to-end testing.

On slide 47, we can review that — some of the provider-initiated beta testing tools. These include the National Coverage Determination, the NCD, or Local Coverage Determination, LCD, conversions to ICD-10, which are available on the — in the NPD database. Additionally, the Medicare Severity Diagnosis Related Groups, or the MS-DRG conversion project, is also available to allow you to know which MS — which ICD-10 codes are related to which DRGs. Integrated Outpatient Code Editor has also been updated for ICD-10 and is available for use for providers and other — to get ready for ICD-10. MLN Matters Special Edition Article SE1409 has additional information about these tools.

Next, I'd like to talk a little bit about acknowledgment testing. Acknowledgment testing began in March of 2014 and is still available for all electronic submitters through September 30th. We also completed four special weeks of testing, where we — where we tallied the results of testers so that we could measure the tester's success at submitting claims for ICD-10.

Throughout the four testing weeks, almost 5,000 submitters submitted test claims, and we received over 160,000 test claims during these four testing periods. The National acceptance rated ranged from a low of 76 percent in November of '14 to a high of almost 92 percent in March of 2015. Most importantly, no Medicare Fee-for-Service claims issues were detected during this testing, and rejections were largely due to issues unrelated to ICD-10.

As we continued our testing program, we also implemented three end-to-end testing weeks. The importance of this testing was to show that not only could claims be accepted into our system, but they could also be processed through all of our ICD-10 editing and produce, finally, remittance advices to the testers. Volunteers were

collected and throughout our testing — three testing periods in January, April, and July of this year. We had over 2,700 testers, and we processed over 67,000 test claims. We thought that — this testing was extremely — it was extremely successful, and during the January and April testing periods, we only found one or two problems, which were fixed in time for the July testing period.

Now, I'm very excited to announce the results from the July round of end-to-end testing. On slide 51, you can see that the July testing was our final opportunity for end-to-end testing, and no system problems were found. During this testing, approximately 1,200 were selected to participate, and almost 500 testers returned from previous rounds to participate in this testing. Approximately 1,400 NPIs were registered for that testing, and many were repeat testers from the previous testing rounds. We received 29,286 test claims into the system, at an acceptance rate of about 87 percent. Most importantly, only 1.8 percent of all test claims were rejected to invalid — due to invalid submission of ICD-10 diagnosis codes or procedure codes.

Again, we'd like to reiterate that no new systems problems were found during our testing. Also, during the testing period, testers were able to retest the problems that were found during the January and April testing, and all of those problems were found to now be corrected and work properly during the July testing.

All of the testers received their remittance advices for the claims that were processed. In addition to the remittance advices, testers received especially generated reports that show the disposition of all of their test claims that let them resolve and review their test results.

The test results that I've just reported here have been posted to the CMS website, and the detailed numbers are available for you to review.

At this time, I will turn it back over to Leah.

Resources

Leah Nguyen: Thank you, Stacey. Slides 53 and 54 have information on CMS resources to help you with your transition to ICD-10. And slides 55 and 56 have information on Local and National Coverage Determinations.

Question-and-Answer Session

Our subject matter experts will now take your questions about ICD-10. The question-and-answer session is intended for providers who may have a question on today's topic. We ask that others please direct their questions to the appropriate representatives at CMS.

Before we begin, I would like to remind everyone, this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. 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, Kalia, 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 the line of Jennifer Wesenick.

Jennifer Wesenick.: Oh, hi, I have a question related to the radio — well, I work for a radiology company. The radiologist actually documenting the specific, I guess, the specific things they're finding. Is there some kind of form or tool that you have to help with the actual radiologist and be more specific with their reports?

Leah Nguyen: Could you hold on for a moment?

Jennifer Wesenick: I'm sorry, what was that?

Leah Nguyen: Hold on for one moment, please.

Jennifer Wesenick: Oh sure.

Leah Nguyen: Hello. Yes, I don't believe we have anything specific that we can point you to on the CMS website, but you may want to get in touch with your specialty society.

Jennifer Wesenick: Probably APR or something. OK. Thank you, though.

Operator: Your next question comes from the line of Carolann Tokarz.

Carolann Tokarz: Hi, yes. I'm trying to understand the initial A and the subsequent D encounter codes as they relate to physical and occupational therapy. I'm looking for some clarification in terms of direct access and a referred patient, seems intuitive that if they're a direct access patient being seen for the first time, they would be coded as an initial if it's an injury, obviously in the injury category of codes. And then if they're

referred, one would think it's subsequent, but I'm hearing two different sides of that story, so could you provide clarification there?

Leah Nguyen: Sure. Nelly, do you want to speak to that?

Nelly Leon-Chisen: This is Nelly. If I understand correctly, when you say direct access, that patient is going directly to the physical therapist, they're not being referred by a physician. And so that would be where the patient is receiving active treatment and that would be your initial encounter.

I think that may sort of depend on different States in terms of what they're allowed to do or not to do. And usually, if someone has already gone through the physician, perhaps they've had something already addressed, then the physical therapy could be a subsequent encounter. But it's very hard to just give you a blanket statement without knowing specifically what the patient had and what kind of treatment was provided because these seven characters are based on whether active treatment is being provided.

Carolann Tokarz: And is there — and thank you. Is there any definition on active treatment, because it doesn't seem — what I'm trying to differentiate is, it doesn't come down to the provider? Does it come down to active vs. just healing, like a recovery phase or subsequent?

Nelly Leon-Chisen: This is Nelly again. There is no specific hard set definition of what active treatment is. There are some examples that are given in the official guidelines, such as surgical treatment, emergency department encounter, and that type of situation. So they're — it's not an all-exhaustive list. But what I think is probably clearer is that for the subsequent encounters, usually those are where there's routine healing or a problem with the healing.

Leah Nguyen: Thank you.

Sue Bowman: To follow up on Nelly's comments, I'd just like to point out to the audience that it would be — it's going to be very difficult for us to answer specific coding questions on today's call due to issues with needing the medical record and getting into a lot of technical issues that may not be helpful to the rest of the audience.

So I would just encourage people to go back to Nelly's slides that talk about the process for submitting a coding question, and also there has been a lot of information, as Nelly alluded to, published in Coding Clinic, giving examples of how to use the 7th character. I just wanted to make that clarifying point.

Nelly Leon-Chisen: Thank you Sue. And as you could tell, I was sort of stumbling because it's like direct access and, you know, trying to think of different scenarios. So thanks for the clarification.

Operator: Your next question comes from the line of Kathy DiCenzo.

Kathy DiCenzo: Hi, I'm wondering, during the transition period, if you feel a provider has used a diagnosis code that's not completely correct, will you be sending any sort of message back on the EOB? Kind of what you did with eRx when you notified people we've accepted this claim? We understand you did electronic prescription.

Stacey Shagena: At this time we don't have any plans to provide any special messaging.

Kathy DiCenzo: OK, thank you.

Leah Nguyen: Thank you.

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

Stephanie Dennis: Yes, this is Stephanie Dennis, and I work at a Long-Term Care and skilled nursing facility, and I've started converting ICD-9 to 10, but I've noticed that PT, OT, and ST all have the same diagnosis code. And I don't know how I'm going to be able to differentiate those diagnosis if they're all sharing the same code.

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

Pat Brooks: I guess, I'm not totally clear that I understand the question. If you're saying, could multiple providers be addressing the same condition, obviously they could at times. And I guess I'm — would come to the same point of Nelly and Sue if — to understand some of these questions, they're somewhat hypothetical, it's really helpful for us if you would send us a medical record that illustrates the issue that's challenging you and say, "My question is what is the diagnosis for whatever based on this documentation?" Or would, maybe your question is, given all these documentations would the surgeon and the attending physician have the same — be treating the same condition? Yes, they could. And could they be treating different ones? Yes, they could, I guess at times, depending on what the focus of care was.

I don't know that I can get into any more detail since I can't exactly get my hands around the question more clearly. But if you send in a clear documentation of the issue that's challenging to the AHA's office, then those of us on the Coding Clinic Board could probably do a better job of responding to the issue.

Nelly Leon-Chisen: This is Nelly, if may I add? Remember that you still have your CPT and HCPCS codes to actually describe the service, and those are not going away. So while the

diagnosis code may be similar because two different types of therapies are being provided for the same condition, that's not something to worry about because your CPT code will actually identify the differences in the services.

Leah Nguyen: Thanks everyone.

Operator: Your next question comes from the line of Stephen Sweetech. Stephen, your line is open.

And that question has been withdrawn. Your next question comes from the line of Bonnie Court.

Bonnie Court: Yes, hello. I was just wondering in terms of the backlog with claims, if you think the turnaround time is going to be significantly delayed for, you know, our claim reimbursement. And if you would — what would you estimate that being?

Felicia Rowe: This is Felicia. There's a standard turnaround time for payment of Medicare claims. It's the 14 days for electronic claims and 29 for paper. So we don't anticipate there being any impact to your payment. In terms of any backlog that may be specific to your local MAC, you might want to pose that question to them if there are any concerns in terms of whether claims will be delayed after 10/1.

Leah Nguyen: Thank you.

Bonnie Court: OK, OK.

Operator: Your next question comes from the line of Debbie Esposito.

Debbie Esposito: Hello, hi, yes. I have a question regarding, we're a Part B provider, and one of our physicians sees patients in a hospital. So if the patient was seen in the hospital on September 28th and 29th, let's say, but discharged after October 1st, and we're not the discharging physician, are we required to use ICD-9 or 10?

Felicia Rowe: And you're submitting your clam for physician services not the hospital service, correct?

Debbie Esposito: I'm sorry, say that again.

Felicia Rowe: Are you submitting the service for the physician rather than the hospital? Or are you submitting …

Debbie Esposito: Yes.

Felicia Rowe: OK, right. You — physician claims, professional claims are — select the correct code set based on the from date of service on your claim. So, whatever — if you're billing for a hospital visit, whatever the date of service of that visit was, that is the code set you'll select.

Debbie Esposito: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Claudia Keenon. Claudia, your line is open.

And that question has been withdrawn. Your next question comes from the line of Keri Clay.

Keri Clay: Hi, my question is about the x placeholders. We had a symposium with our MAC awhile back where they were talking about using those, but it wasn't talked about in this meeting, so I'm just wondering if those are still going to be used?

Sue Bowman: This is Sue. I think I can answer that. You're talking about the placeholders in the ICD-10-CM codes when there's a 7th character that applies, but the base code is fewer than six characters. Is that what you're referring to?

Keri Clay: Yes.

Sue Bowman: Yes, I mean, this — we didn't get into all of that today because this was not really a how to use the coding system type of program. But yes, there are x placeholders that you have to use whenever you have a code that's fewer than six characters but it has a 7th character that's applicable to the code because the 7th character has to be in the 7th character position.

Keri Clay: Great, thank you.

Pat Brooks. And this is Pat Brooks, and just to point out, the ICD-10 basics that Sue did previously for us, I think goes into some nice detail on that biller code issue. If you want to learn more about it, you may want to look at some of our previous postings.

Operator: And your next question comes from the line of Edith Perez.

Edith Perez: Yes, hi. My question was, I work for a surgical center and we use UBs, we charge for facility. Do we need to change our forms or what specific — I know we have to use ICD-10, but does the form change? I know we have to use a new form for physicians. But does that apply to a surgery center or outpatient surgery center?

Felicia Rowe: Hi, this is Felicia. The forms are not changing as a result to the transition to ICD-10. So whatever form you're currently using today, you'll continue to use that after October 1st.

Edith Perez: OK. Thank you so much.

Felicia Rowe: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Evelyn Maupin. Evelyn, your line is open.

Evelyn Maupin: Yes, thank you. My question is in regards to the ICD-10 diagnosis codes that have a left and right. I'm just wondering if we're using — if we're trying to bill something that is both left and right, I'm guessing we have to list it twice on the claims, and we don't use modifiers on the CPT codes? Or do we still use the modifiers?

Felicia Rowe: Hi, this is Felicia. At this time you're still required to use the modifiers for laterality. The ICD-10 diagnosis codes are not replacing those modifiers.

Evelyn Maupin: So if we're billing for right and left, then we put two ICD-10 diagnosis codes on there, one that indicates right, and one that indicates left?

Felicia Rowe: Pat or one of the coders, you may have to speak to this. I'm not sure if there are certain diagnosis codes that might be bilateral.

Pat Brooks: Yes. And Sue can probably go into a detail of this, too. But if there's a choice when you get to the tabular, and you're looking up the condition, and you see a choice for just left and right, you might have to report whatever the diagnosis is twice. But if when you look there, you see the choice of a bilateral, then you could select that. So that' just applies on the ICD-10-CM side. But as was stated earlier, you don't change your reporting practices with your CP HCPCS and use the modifier. ICD-10 doesn't impact that.

Evelyn Maupin: OK, so we still have to use our modifiers regardless?

Pat Brooks: Yes, ICD-10 does not impact your reporting CPT or HCPCS. You continue doing just the same way with the same rules.

Evelyn Maupin: So there won't be a conflict if say, for instance, we have the wrong modifier and it doesn't match up to the ICD-10, that's not going to be an issue?

Pat Brooks: I think you heard from our flexibility statement where we're not going to audit specifically if you're in the same family of codes. And for a condition, let's talk about hip fractures on both sides, and it's a hip fracture. In that first year, they'll be some understanding if you have trouble getting down to the — all the digits as long as you have a valid code.

So my suggestion to you would be, when you code, you know how you do your CPT and your modifiers, you're probably doing just fine on that now. When you look up your diagnosis code, try to find the condition, and then try to find if it involves left or right, whatever the issue is. See if the ICD-10-CM code provides that choice, and then choose those based on the doc — what you see in the tabular section of the book.

But there won't be specific audits on those in the first year, as long as you've got the overall condition correct. There are may be audits on CPT codes that happen now if there's a coverage or edit problem there. I can't speak to that.

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

Stephanie Moore: Um, yes, I have a question specific to DME billing. I am referring to Med Learning Matters 7492, and our question is, is whenever you have supplies that are being billed from — even from year to year, once a year for yearly supply or for a 3-month or 1-month supply, how are those supposed to be handled, because according to the way we're interpreting this, they are going to span between one another, and we just want to accurately know — or know accurately what dates and if they should be split? Should we be looking at the from date or the through date? Or could you give us more guidance on that?

Felicia Rowe: Hi, this is Felicia Rowe. If you're referring to capped rental claims, is that what you're referring to?

Stephanie Moore: Yes, yes.

Felicia Rowe: Right. For capped rentals, you're typically billing on a monthly basis. So, you're going to select the appropriate code set for those claims that span the October 1st date. You're going to select the appropriate code set based on the from or the beginning date of service for that capped rental claim. So if the capped rental starts in September but ends in October, you would use ICD-9 codes. You do not split those claims.

Stephanie Moore: OK, thank you.

Felicia Rowe: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Tatio Ture.

Tatio Ture: Yes, hi. My name is Tatio Ture. Actually, my question has been answered.

Leah Nguyen: Great, thank you.

Operator: Your next question comes from the line of Lee Chen.

Lee Chen: Yes, hi. I was converting my codes, and I need a definition of certain terms used under code for specificity. For example, like for anaphylactic reaction, there were three codes, initial, sequela, and subsequent. Can you define those three terms?

Leah Nguyen: Sue or Nelly, do you want to define those?

Sue Bowman: This is Sue, and I think that's going into more detail — we can go in – in this call if you subscribe to Coding Clinic, there's a lot of examples in there and also the ICD-10-CM Coding Guidelines that we referred to in the slides. There should be a link there. Those guidelines are on both the CMS and the National Center for Health Statistics websites, and the terms are explained in there exactly how they're defined.

Leah Nguyen: Thank you Sue.

Lee Chen: Thank you very much.

Leah Nguyen: Yes, I think we have time for one final question.

Operator: The next question comes from the line of Mary Inabnit.

Mary Inabnit: Hi, I am the authorization manager for a home health. And my question is, we have authorizations that started prior to 10/1 and go past 10/1, and we have — we bill by the diagnosis code. And I was wondering, is it our responsibility to get the ICD-10 codes for those authorizations that we have in place?

Felicia Rowe: Hi, this is Felicia. What sort of authorization are you referring to? I just want to make sure I'm clear on your question.

Mary Inabnit: Oh, yes. We do — we go in homes and do home health to people like ADLs and IDA, DLs, stuff like that.

Felicia Rowe: And these authorizations are coming from those entities?

Mary Inabnit: Yes, they're coming from providers, …
Felicia Rowe: OK.

Mary Inabinet: Insurance.

Felicia Rowe: OK, I tell you what, why don't you send me that question separately. It's to the ICD-10 implementation planning mailbox. I want to make sure I understand it a little better, and we're running out of time?

Mary Inabnit: OK.

Felicia Rowe: So if you send it to …

Leah Nguyen: It's listed on slide 57.

Mary I Inabnit: What is it? I did not catch that.

Leah Nguyen: If you could email your question to the email address listed on slide 57.

Mary I Inabnit: Oh OK. I got that. OK.

Leah Nguyen: We could take a closer look at that.

Mary Inabnit: OK, will do.

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 57.

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 59 of the presentation, you will find information and 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, please note 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.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connect Call on Countdown to ICD-10.

Have a great day everyone.

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

-END-


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