



MLN ConnectsTM

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services
ICD-10 Basics
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today’s MLN Connects National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

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

Announcements and Introduction

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

Are you ready to transition to ICD-10 on October 1st, 2014? Thank you for joining us today for a keynote presentation on ICD-10 basics by Sue Bowman from the American Health Information Management Association, or AHIMA, along with an implementation update by CMS. A question-and-answer session will follow the presentation.

Before we get started, I have a couple of announcements.

You should have received a link to the slide presentation for today’s call in previous registration emails. If you—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, select “National Provider Calls and Events,” then select the date of today’s 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 specific credentialing organization.

At this time, I would like to turn the call over to Pat Brooks from the Hospital and Ambulatory Policy Group of the Center for Medicare for an ICD-10 update.

ICD-10 Update

Pat Brooks: Thank you, Leah.

I would like to begin with slide 6, where we’re going to discuss ICD-10 implementation. It’s now a little over a year from when we will implement ICD-10. October 1st, 2014, is

the compliance date for the implementation of ICD-10-CM for diagnoses and ICD-10-PCS for procedures. There will be no more delays.

Those who have been postponing ICD-10 implementation planning thinking there might be additional delays should really begin to plan implementation now. There will be no more delays to the ICD-10 implementation date.

ICD-10-CM, the diagnosis, will be used by all providers in every health care setting. We've asked Sue Bowman of AHIMA to give an overview of this system since it is so important to all users.

After the teleconference, I would urge all of you to either go to a 2014 ICD-10-CM code book or you can look at our electronic files on the CMS website and start using both the index and the tabular system to code a few common diagnoses that you have in your systems.

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

I'll let you know that the last update to ICD-9-CM will occur on October 1st, 2013. There will be no other updates to ICD-9-CM because we are moving to ICD-10.

Moving on to slide 7, we'll discuss the actual implementation date of October 1st, 2014. This will be determined by the date of service for ambulatory and physician reporting, and that is the ambulatory and physician services provided on or after October 1st, 2014, you'll use ICD-10-CM diagnosis codes.

For the date of discharge for hospital claims, that will be determined when you will use ICD-10. So for inpatient discharges occurring on or after October 1st, 2014, you will use ICD-10-CM and ICD-10-PCS codes.

On slide 8, you will see that there will be no impact on CPT or HCPCS codes. Physicians and ambulatory services will continue to use both CPT and HCPCS.

On slide 8, we discuss some ICD-10 MS-DRG updates. We now have posted on our CMS website version 30 of the ICD-10 MS-DRGs. And that's the version that mimics the ICD-9 version of the MS-DRGs currently used by hospitals.

We have the definitions manual posted in both text and HTML versions. We also have a document that shows changes made between version 29 and version 30 of the ICD-10 MS-DRGs. We also have the definitions of the Medicare code edits.

The final fiscal year 2015 ICD-10 MS-DRGs version 32 will be subject to formal rulemaking.

On slide 10, we show that we have available for order both the mainframe and PC versions of the software for version 30 of the ICD-10 MS-DRG, and we're making that available through NTIS, through the links we show on slide 10.

On slide 11, we begin to share some MLN resources. At the top of slide 11, you'll see some MLN Matters® articles that will be of great interest to you if you have not seen them before—some on the ICD-10 implementation, the partial code freeze, and what to do with claims that span the implementation period.

At the bottom of slide 11, you'll see some links to four factsheets that have been updated recently that cover important information about ICD-10. You can go to these factsheets, print them out, and use them to train others in your organization about ICD-10.

On slide 12, we provide information on how you can sign up for an ICD-10 Industry Email Update so that you'll get periodic information about happenings with ICD-10 and help you prepare for ICD-10.

At the bottom of slide 12 is a link to the CMS-sponsored ICD-10 teleconferences like the one we're having today. You can go listen to prior teleconferences and get important information if you've missed some of these, and you can get information about future ones that are planned, through that website.

On slide 13, we give a couple more important websites, the Medicare Fee-for-Service Provider Resources and the Provider Resources.

At the bottom of slide 13, we give a link to the ICD-9-CM Coordination and Maintenance Committee. This is the committee that discusses updates to both the ICD-9 and ICD-10 coding system. The next meeting of this committee will be on September 18th through 19th, 2013, about a month away, and we will be live streaming this committee meeting if you care to listen to it over the Internet through your office or at home. This committee will be renamed the ICD-10 Coordination and Maintenance Committee beginning with our March 2014 meeting, because, as I stated earlier, we're not going to be updating ICD-9-CM anymore. And just information to let you know that by listening to these Coordination and Maintenance Committee, you can get free CEUs for some organizations, such as through AHIMA.

The bottom of slide 14 shows two organizations that agreed to share ICD-10 resources. If you're looking for some special software or educational material or additional resources, you can look at these two organizations' websites to see what's available.

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

Keypad Polling

Leah Nguyen: Thank you, Pat.

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

Victoria, we're ready to start polling.

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

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Thank you. I would now like to turn the call back over to Ms. Leah Nguyen.

Leah Nguyen: Thank you, Victoria.

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

Keynote Presentation

Sue Bowman: Thank you, Leah.

On slides 16 and 17, I've listed some of the benefits of ICD-10-CM. I'm not going to read these all to you, but the important point to remember that—as you all prepare for the transition to ICD-10, keep in mind that coding isn't just for reimbursement. And even within the realm of reimbursement, future reimbursement models are likely to be quite different from today's reimbursement systems and even more dependent on health care data.

Current and emerging initiatives aimed at promoting value in health care really can't be successful without good health care data. And a more modern code set, like we're moving to with ICD-10, will permit a level of precision that hasn't been possible in the past, enabling more meaningful data and analytics and greater health intelligence.

ICD-10-CM: The Basics

So on slide 18, we will talk about the difference in the structure between ICD-9 and ICD-10. I won't go over the structure of ICD-9; I'm sure you're all pretty familiar with that.

But ICD-10-CM has three to seven characters, and I'll go into more detail on some of those later. The first character is alpha, and all of the letters of the alphabet are used except for the letter U. The second character is numeric, and characters three through seven can be either alpha or numeric. There's a decimal after the third character, which is the same as in ICD-9 today.

And it's important to keep in mind that the alpha characters are not case sensitive. So what does that mean? If you see the example in the parenthetical on slide 18, you'll see that the leading letter S and the seventh character A can appear either as an uppercase or a lowercase letter without affecting the code, and both ways of displaying the code are valid.

On slide 19, we're going to talk a little bit about some of the similarities to ICD-9-CM, and there's quite a few similarities. In the tabular list, which is the list of code numbers, it's still a chronological list of codes divided into chapters based on body system or condition. It has the same hierarchical structure like ICD-9-CM has, and most of the chapters are structured similarly to ICD-9-CM, with a few exceptions. A few chapters have gone under some restructuring, and the sense organs, the eye and ear, have been separated from the nervous system chapter and moved to their own chapters.

On slide 20, the index is still an alphabetical list of terms with their corresponding codes. Indented sub-terms appear under the main terms, and for those of you who are coders, you'll understand what that means. And the index is structured similarly to ICD-9-CM, with an alphabetic index of diseases and injuries, an alphabetic index of external causes, a table of neoplasms, and a table of drugs and chemicals.

On slide 21, many of the conventions used in ICD-9-CM are also used in ICD-10-CM and have the same meanings. Some of the—all the abbreviations, punctuations, symbols, many of the notes, such as “code first” and “use additional code” notes, are also used in ICD-10-CM and have the same meaning.

Nonspecific codes—or “unspecified” or “not otherwise specified” codes, as they're called—are still available to use when detailed documentation to support more specific codes is not available. And we'll talk a little bit more about that later.

And codes are looked up the same way. You still look up the diagnostic term in the alphabetic index and then verify the code number in the tabular list. And a little bit later, we'll walk through a few examples to show how a code would be looked up in ICD-10-CM and then verified in the tabular.

The codes are invalid if they're missing an applicable character, just like they would be in ICD-9-CM. And there is a set of official guidelines for coding and reporting for ICD-10-CM that's very similar to ICD-9 with just some additional sections to address some of the differences in ICD-10-CM. And on slide 22, there is a link to where you can find those official coding guidelines. And just with—as with ICD-9, adherence to the official coding guidelines is required under HIPAA.

But, of course, there are some differences from ICD-9-CM, or there wouldn't be much point in making the switch to a new coding system. So on slide 23, we're going to start talking about some of the differences.

The biggest difference is the level of detail and specificity. For those of you who have taken a look at ICD-10-CM, you know what I'm talking about. There's a lot more detail, a lot more specificity. Laterality, meaning the side of the body that's affected, has been added to relevant codes. And there's a lot of combination codes to capture certain conditions and their associated common symptoms or manifestations. There's also some combination codes for poisonings and their associated external cause.

On slide 24, one change in the ICD-10-CM system is that injuries are grouped by anatomical site rather than the type of injury. And what do I mean by that? Well, in ICD-9-CM, injuries are grouped by fractures, dislocations, sprains and strains, and then within those categories, they are grouped by anatomical site.

In ICD-10-CM, it starts off with structure by anatomical site, like injuries to the head, injuries to the neck, thorax, and so forth. And within those sections, it breaks it down by the type of injury to that part of the body.

The codes in ICD-10-CM better reflect modern medicine and updated medical terminology. And it's important to keep in mind that ICD-10-CM has not remained static since it was originally developed. It's been continually updated since its initial development, both to reflect changes to the World Health Organization's ICD-10, as well as in response to requests for modifications to the Coordination and Maintenance Committee from groups within the U.S.

On slide 25, I provided a few examples of what some of the combination codes look like. I won't read them to you, but you can see from looking at these some of the kind of details that are put together with common conditions and some of the manifestations they have, such as Crohn's disease with obstruction, and diabetes with the relevant diabetic manifestations.

On slide 26, one of the big changes in ICD-10-CM is the addition of a seventh character, which isn't used in certain—isn't used in every chapter. It's used in certain chapters, including OB, injury, musculoskeletal, and the external cause chapters. And it has a different meaning depending on the section where it's being used. So within a particular section, the meaning will be consistent, but across all of the sections where it's used, the meaning will be different. It always has to be used in the seventh character position. And

when the seventh character applies to a code, any code missing that seventh character is considered an invalid code.

So on slide 27, here is a description of what some of the seventh characters are used for. A very common use is to describe the type of encounter. An initial encounter seventh character is when the patient is continuing to receive active treatment for the condition. So, encounters for things like surgical treatment, the emergency department encounter after the injury occurred, going to see a new physician for evaluation of the injury, such as primary care physician sending the patient to an orthopedic specialist—that is an example of how the initial encounter would be used.

The subsequent encounter does not refer to a repeat incidence of the same injury. It refers to the same injury as the initial encounter, but it's referring to encounters after the patient has gotten the active treatment and is now just continuing to receive routine care during the healing or recovery phase. So, examples that I've listed there include coming back for a cast change or removal, or removal of external or internal fixation device, or aftercare. You know, we have we different aftercare V-codes in ICD-9. In ICD-10-CM, if you return for aftercare of an injury, you use the acute injury code with the seventh character indicating subsequent encounter. So, that would be a very common use of the seventh character for the subsequent encounter.

Sequela refers to complications or conditions that arise as a direct result of a condition. And an example of that would be scar formation.

On slide 28 is an example of some of the seventh characters for fractures. And you can see it breaks it down by the initial, subsequent, and sequela that I just talked about. But it also has further division to identify the open or closed fracture, and then fractures with routine or delayed healing, or nonunion or malunion.

On slide 29, another new feature in ICD-10-CM is a dummy placeholder X, which is used in certain codes to allow for future expansion of those codes. And it's also used to fill out empty characters when a code containing fewer than six characters has a seventh character applicable to that code. So, as I mentioned earlier, the seventh character always has to be in the seventh character position. So, if a particular code is not six characters long, then you have to use the placeholder X to fill up the empty spots in order for the seventh character to appear in the seventh character position. And I'll give a couple of examples of that later on. Some code book publishers are displaying the placeholder X in the codes that require them in their code books so that you don't forget to include it as part of the reported code.

Just like the other alpha characters in ICD-10-CM, the placeholder X is not case-sensitive. So, it can be displayed as a lowercase or uppercase X and it's still perfectly valid. And that's what we're showing on slide 30.

On slide 31, another new feature of ICD-10-CM is the distinction between two different types of excludes notes. An excludes1 note means that the code identified in the note and

the code where the note appears cannot be reported together because the two conditions can—be mutually exclusive and cannot occur together.

So, for—in this example, for—the same patient wouldn't have both type 1 and type 2 diabetes. It would be one or the other. So under the category for type 1 diabetes, there is an excludes1 note indicating that type 2 diabetes would not be coded here, and the two codes would not be reported together.

The other type of excludes note is an excludes2 note, which appears on slide 32. And that indicates that the condition identified in the note is not part of the condition represented by the code where the note appears. So both codes may be reported together if the patient has both conditions.

So, the example here would be under the category for a pressure ulcer. A patient could have a pressure ulcer and also other kinds of ulcers, such as a diabetic ulcer or a varicose ulcer. So this is saying the pressure ulcers don't—pressure ulcer codes don't include these other kinds of ulcers. If the patient also has these other type of ulcers, they should be separately coded with different codes.

So this distinction between excludes1 and excludes2 notes is an extremely helpful new feature in ICD-10-CM. ICD-9-CM doesn't have this distinction, which has led to a lot of confusion and questions being raised over the years as to the meaning of some of the excludes notes in ICD-9, because an excludes note in ICD-9 could have either one of these two meanings, and you don't know which it is because they are not identified with this excludes1 and excludes2 distinction. So this is a really great feature in ICD-10.

Coding Examples

On slide 33, I've just provided you with some examples of some of the expanded specificity that appears in the ICD-10-CM codes so you have a flavor for what some of these codes look like.

And on slide 34, I've provided some examples of the addition of laterality to the codes to show the kinds of codes where that attribute features in.

ICD-10-CM Codes

Now, on slide 35 we're going to walk through a few coding examples so that you can see the process of how you code in ICD-10-CM and see how similar the process is to ICD-9, even if the code you arrive at is different than it would be in ICD-9. And I know not all of you are coders, but this will give you a general idea of what the process is and what's involved.

So, the first one is type 1 diabetes with diabetic nephropathy. Well, you would look up the main term of "Diabetes" in the alphabetic index, look at the indented entries underneath to see which one applies to your particular situation that you're trying to code, and you will see "type 1" listed there with an indented term for "with nephropathy."

So then you would go to E10, and then E10.21, as mentioned in the index. And the tabular part is shown on slide 36. And you will see that E10.21 is the code for type 1 diabetes with diabetic nephropathy.

On slide 37, the diagnosis of acute cystitis with hematuria. So, you would look up the main term of “Cystitis” in the alphabetic index, then the indented entry for “acute” and then “with hematuria.” And you’ll see N30.01 listed.

Note the default. And we will talk a little bit more about defaults a little later. But, if you didn’t know there was—if there was hematuria or not, you can see the default takes you to N30.00, which I’ll show you in a second, is the code for without hematuria. So, it’s important to know that the classification does sometimes use these defaults when you don’t have the specific information to get you to the more specific code.

So now you go to the N30 section of the tabular, and you find N30 and then N30.01 (it’s index-directed), and see that acute cystitis with hematuria is correctly coded N30.01. Notice the “use additional code” note under the category N30, indicating that you would use an additional code to identify the infectious agent. So, if you knew the infectious agent, you would code that as well.

On slide 39—excuse me—is an example for chronic obstructive pulmonary disease. You would look up “Disease, pulmonary, chronic obstructive.” You’ll see J44.9 listed. If you go to the tabular, look under the category of J44—and what’s listed on J44 is split between slides 40 and 41. And then you—on slide 41, you’ll see that J44.9 is the code for chronic obstructive lung disease not otherwise specified.

On slide 42, let’s look at an injury example—fracture of proximal third of scaphoid bone, left wrist, initial encounter. So, look up the term in the alphabetic index of “Fracture, scaphoid.” It says to see also “Fracture, carpal, navicular” because that’s another term for the scaphoid bone. So, then you look up “Fracture, carpal bone, navicular.” You’ll see “proximal third, S62.03” listed.

And one point I’d like to make before we go any further on this particular slide is, notice in the diagnosis, I did say “initial encounter.” Now, you might be wondering, does the physician have to specifically document initial encounter in order for us to be coding this particular diagnosis that way? And the answer is no. You would be able to tell from the description of the patient’s history whether this is a new fracture presenting for initial evaluation and treatment, or whether the encounter is for ongoing care of a previously treated fracture. So the coder would use that information to determine whether it should be coded as an initial encounter or a subsequent encounter without the physician having to specifically state that.

So now we move on to S62 in the tabular to take a look at that. And you will see two notes listed under S62. One says, “A fracture not indicated as displaced or nondisplaced should be coded to displaced,” and “A fracture not indicated as open or closed should be

coded to closed.” And you will notice in our diagnostic description, we did not—it was not specified whether it was displaced or nondisplaced or open or closed. So, this provides you direction of how that should be coded in the absence of that information.

And we also need to apply the appropriate seventh character, as shown on slide 44. And we already know it’s an initial encounter. It didn’t say open or closed, but we have the note that we just read that said that if it’s not specified as open or closed, it should be coded to closed.

So then, on the next slide—the next two slides, slides 45 and 46, it shows what the listing of codes look like under S62. And so the correct code assignment for this diagnosis would be S62.032A, to indicate that it’s a displaced fracture because of our note that said if it doesn’t specify displaced or nondisplaced, you code as displaced. It’s the proximal third of the scaphoid bone of the left wrist, and the A is showing that it’s an initial encounter for a closed fracture.

So that was a little bit more complicated one. But you could still see that the index entries and the instructional notes under the code number guided you to the correct code.

So for our last example for this section, we’ll take a look at a mental health diagnosis of anxiety reaction. So, you will look up the main term “Anxiety”—and these terms on slide 47 should actually be a little bit indented under Anxiety—and you scroll down and you see “Anxiety reaction,” which is the diagnosis that you’re coding, F41.1. So you go to the tabular list and see that F41.1 is indeed the correct diagnosis, because “Anxiety reaction” is listed as an inclusion term.

ICD-10-CM Unspecified Codes

All right. On the next slide, slide 49, we’re going to talk for a minute about the use of unspecified codes.

The four cooperating parties responsible for the official ICD-10-CM coding guidelines—CMS, the American Hospital Association, the American Health Information Management Association, and the National Center for Health Statistics—recently approved a statement explaining the appropriate use of unspecified codes, because there’s been some misinformation out there about if these will be allowed under ICD-10. This official statement is available on all four of our organizations’ websites.

But basically, in the next couple of slides, I’ve highlighted the key points here, which is that each health encounter should be coded to the level of certainty known for that encounter. Unspecified codes, frankly, should need to be selected less often due to a greater number of code choices in ICD-10-CM. And that seems maybe a little counterintuitive, but when you match up the documentation in the record with the more specific code choices in ICD-10-CM, you may find that you actually don’t even need the unspecified codes that often.

But unspecified codes should be reported when they most accurately reflect what is known about the patient's condition at the time of the particular encounter. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it's totally acceptable to report the appropriate unspecified code. It would not be appropriate to select the specific code that's not supported by the medical record documentation, or conduct medically unnecessary diagnostic testing just—in order to determine a more specific code.

But you need to keep in mind that while unspecified codes are available in ICD-10-CM, the use of these codes impacts the completeness of coded data and should only be used when no specific code is available or a more specific diagnosis is not yet known. And as I showed in some of the earlier coding examples, in addition to unspecified codes, sometimes ICD-10-CM uses defaults for some conditions, which are indicated by index entries or inclusion terms under the codes, such as the closed and displaced fracture example that I presented a few minutes ago.

So let's look at an unspecified—a couple of unspecified code examples, starting on slide 51. Let's look at the fracture of the left wrist that we coded earlier, but assuming that we have less information than we had before. We still know that it's traumatic. We're going to assume here that it's traumatic, that we know that it's the initial encounter. But we don't know the specific bone, the scaphoid bone that we knew before. All we know is that it's the left wrist. So, we look up the main term of "Fracture, wrist." It says, "carpal—see Fracture, carpal bone."

Then on the next slide, slide 52, you look at S62 in the tabular. You see those same notes about displaced and closed fractures that we had talked about earlier. We still have to pick our appropriate seventh character on slide 53. And then on slide 54, we see the code of S62.10, which has an inclusion term of "Fracture of wrist not otherwise specified."

And then we see "S62.102, Fracture of unspecified carpal bone, left wrist" because we do know it's the left wrist. And we would add the seventh character of A for the initial encounter for closed fracture, because, again, if you don't know if it's open or closed, the default in ICD-10-CM is closed. So that's an example of how you would get to the unspecified wrist fracture code.

Another example on slide 55 is pneumonia. Look up the main term of "Pneumonia." It shows J18.9. You go to the tabular on slide 56. It shows "Pneumonia, unspecified organism." This is what we're trying to code, so the code assignment would be J18.9.

Notice the "code first" note under J18 for associated influenza. There was no mention of influenza in our diagnosis example, so we wouldn't—this note doesn't apply. We wouldn't code the influenza in this case. But, if influenza had also been documented, per this instructional note, it would be coded first, and then the pneumonia code.

ICD-10-CM External Cause Codes

On slide 57, we're going to talk a little bit about external causes of morbidity coding. The four cooperating parties that I mentioned earlier approved a statement on the external cause codes in ICD-10-CM. And just like the statement I mentioned earlier about the use of unspecified codes, this statement is available on all four of our websites.

There is no national requirement for mandatory ICD-10-CM external cause code reporting. There is no national requirement for external cause coding under ICD-9-CM either. Reporting of ICD-10-CM codes in the external cause chapter is only required for providers subject to a State-based external cause code reporting mandate or a payer requirement. Over the years, unrelated to the transition of ICD-10-CM, the number of States requiring external cause code reporting has grown because of the additional valuable information these codes provide about how and where the injury occurred.

But, unless you are required by a payer in your State or by a State data agency to report external cause codes, and you haven't been reporting them in the past and aren't aware of any new requirement coming down the pike in the future, then you are not required to report them under ICD-10-CM either. Of course, in the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report these codes because they do provide valuable additional information.

So why is external cause information useful? Well, on slide 58, I've explained that they provide valuable data for injury research and evaluation of injury prevention strategies. And these codes are used at the national, State, and local levels to identify high-risk populations, set priorities, and plan and evaluate injury prevention programs and policies, and are potentially useful for evaluating emergency medical services and trauma care systems.

Improving the availability of and access to high-quality external coded—cause-coded data can benefit auto insurance companies, disability insurers, health insurance plans, public payers, health care purchasers, employers, businesses, labor unions, schools, and other entities who are interested in injury prevention and safety issues. So that's the role of these codes.

On the next slide, I provide an example of how you would assign an external cause code in ICD-10-CM. So we have an injury sustained from falling down ice-covered steps, initial encounters. Like other codes in ICD-10-CM, the process of assigning an external cause code is the same as in ICD-9-CM.

And so you would look up the main term in the external cause index, this time, of "Fall." And then you see indented entries of "from," "stairs," and "due to ice or snow." These—on this slide, it's not really showing the indents properly—the "stairs" should be indented under the "from" line, and then the "due to ice or snow" should be indented a little bit under "stairs." And you will see W00.1 listed.

If you go to the next slide, verifying the code in the tabular, you'll look up "W00 Fall due to ice and snow." It does require a seventh character that you'll see there. And it's indicating the initial encounter, subsequent encounter, or sequela. And then you will see "W00.1 Fall from stairs and steps due to ice and snow."

Now, you'll notice this is only a four-character code and you need a seventh character. So, this is an example where you would need to use the placeholder X. So you have W00.1, and then you have XX, and then A for the initial encounter because the seventh character must appear in the seventh character position.

And as I mentioned earlier, some code book publishers, also encoding vendors and others, have added these Xs to the codes in their code books where they're applicable so you don't forget to include them.

Documentation

So what is the impact of the ICD-10 transition on medical record documentation? We keep hearing that with all this specificity, so much more documentation is going to be needed.

Well, as the Department of Health and Human Services noted in the 2009 ICD-10 final rule, improved medical record documentation is not predicated on the change from ICD-9-CM to ICD-10-CM. Rather, improved medical record documentation is being driven by initiatives such as quality measurement reporting, value-based purchasing, and patient safety. And any potential improvements in medical record documentation is really just a positive outcome of the move to ICD-10, but not required solely for ICD-10. With better and more accurate data, patient care can only be improved.

So on slide 61, better clinical documentation promotes better patient care and more accurate capture of acuity and severity that can be used for quality measures, reimbursement, severity-level profiles, risk adjustment profiles, present on admission reporting, hospital-acquired conditions. On slide 62, high-quality documentation can also help to avoid misinterpretation by third parties, payers, auditors, attorneys in legal cases, and also justify medical necessity. So there's a lot of reasons for documentation, and the increased specificity of ICD-10 is just one of these many reasons.

So, on slide 63, you need to start off by assessing the quality of the medical record documentation to identify improvement opportunities. You can't just go out there and improve documentation if you don't know what's wrong with it today or how it needs to be improved. And you might be pleasantly surprised to find more documentation is available to support the increased detail in ICD-10-CM than you expect.

A lot of clinical information documented today is being lost when it's translated to ICD-9-CM codes for external reporting purposes because many of the ambiguous or broad ICD-9-CM codes don't need some of the details contained in the documentation. So the information is buried there in the medical record, but it's just not represented in the vague ICD-9-CM code that's coming out of the process.

So, as you do a documentation gap analysis, on slide 64, consider a variety of different medical record sampling techniques—a random sample, sampling by clinical specialty, looking at your top diagnoses, top service lines, high-volume diagnoses, and diagnoses known to represent documentation problems today, because chances are if they're problematic today, they are not going to go away when ICD-10-CM is implemented.

On slide 65, make sure you identify documentation improvement opportunities that could impact multiple initiatives. Don't look solely at the ICD-10-CM codes and what documentation is needed to support them, but how could you improve documentation for Meaningful Use, hospital-acquired conditions, value-based purchasing, State reporting requirements? Where else could the documentation be improved? Because if the documentation is better overall, then it's going to support all the different things going on, not just ICD-10.

And try to determine the best solution for addressing each documentation gap. Don't have one solution for everything because one size doesn't fit all. So examples of some of the approaches to improving documentation include modifications to forms or templates to capture the information, adding things to EHR documentation templates or having EHR documentation prompts, further education on different topics of where more detailed documentation is needed, and workflow or operational process changes might be something that needs to be done.

And don't try to bite off everything at once. Prioritize. Start with the low-hanging fruit or issues that would have the greatest impact if the documentation was improved.

On slide 66 are a few examples of ICD-10-related details that could be added to EHR templates, like capturing laterality, making sure the encounter type is clear. I think initial and subsequent is going to be pretty clear from the patient history. But it may not be so clear whether it's a routine healing or delayed healing, and that might be information that needs to be captured. More specific anatomic details could be added to EHR templates; severity, such as the stages of chronic kidney disease, and relationships among diseases could be identified through prompts, as well.

ICD-10-CM Training

And on slide 67, plan your educational strategy for ICD-10-CM training. Who will need education? What type and level of education will be needed? For example, only hospital inpatient coders are going to need to learn ICD-10-PCS.

It's estimated, probably (at least in our experience at AHIMA) 3 to 4 days for coders to learn ICD-10-CM. But this is somewhat dependent on the individual's level of ICD-9-CM knowledge and what formal background they've had in coding education or the biomedical sciences already. Additional training may be needed to refresh or expand people's knowledge in the biomedical sciences.

And so, you should use assessment tools to identify coders' areas of strengths and weaknesses, and then review and refresh the knowledge of biomedical concepts as needed based on the assessment results. So don't just give everyone—throw a remedial training at anatomy and physiology and pathophysiology at everyone, and figure they need it and they all need the same amount. Really assess where people's gaps are and then focus that additional training on covering that gap.

And keep in mind that training for coders working in a medical specialty area can focus on code sections most applicable to that specialty. Obviously, some of the general attributes I've talked about—like how the seventh characters work, and what the different conventions mean, and what an excludes1 note and excludes2 note is, and a placeholder—that's something everyone needs to learn. But maybe if most of their coding is focused in a particular specialty area, you can focus most of their training on the coding issues related to that particular specialty.

And consider how education will be delivered, when should the education be provided. It's typically recommended that intensive coder training should be provided about 6 to 9 months prior to implementation. That sort of depends on how many coders you have, what else the coders are helping with—with the ICD-10 implementation process where they might need training earlier in order to help with those initiatives.

But, the idea behind the 6- to 9-month timeframe is that if you train the coders too early and then they're continuing to work in ICD-9 up until the implementation date, they've now forgotten what they have learned, and now you have the added cost of some additional training to refresh them when it's time to implement ICD-10.

Coder training is available from many, many sources—not even all, you know, represented on this slide, slide 69: professional associations, medical specialty societies, State medical societies, commercial entities, independent consultants. And there are many, many formats—online, both self-paced and instructor led; face-to-face, both on site at your own organization or off site; and as many price points as there are sources and formats. So there are a lot of training choices and options out there.

General Equivalence and Reimbursement Mappings

So before I conclude my presentation, let's just have a brief word about the GEMs and the reimbursement mappings. I'm on slide 70 now.

The General Equivalence Mappings, the GEMs, are designed to aid in converting applications and systems from ICD-9-CM to ICD-10-CM and PCS. And the reimbursement mappings are a temporary mechanism for mapping claims containing ICD-10 codes to reimbursement-equivalent ICD-9 codes.

But a key point I really want everyone to take away from this session today, on slide 71—and highlight this if you've printed the handout out. But, the maps—neither the GEMs nor the reimbursement mappings should be used to assign codes to report on

claims. The GEMs and the reimbursement mappings are not a substitute for learning how to use the ICD-10 code sets.

Mapping is not the same as coding. Mapping links concepts in two code sets without any consideration of the context or medical record documentation, whereas coding involves the assignment of the most appropriate codes based on medical record documentation and applicable coding rules and guidelines.

Frequently Asked Questions

I also wanted to touch on just a couple of the most common questions that we get a lot, and that I'm sure CMS gets as well.

And on slide 72, the first one is “Since ICD-10-CM has many more codes, is it more difficult to use than ICD-9-CM?”

Well, the analogy I like to use is to compare it to using a dictionary or a phone book. A dictionary or a phone book has a lot of terms or numbers in it, but it doesn't really—that doesn't really make it harder to use. And when you add more words to the dictionary or add more phone numbers to the phone book, it doesn't add to the complexity of using that resource.

So just—under the same concept, the more detail and clinical accuracy and specificity in ICD-10-CM really make the system easier to use than ICD-9-CM because instead of scratching your head about which of the vague codes with the outdated clinical terminologies—the right code for this particular clinical situation, it's much more specific, and you can immediately tie it to the documentation of the diagnosis that you're talking about. Because ICD-10-CM is much more specific, more clinically accurate, and uses a more logical structure, it's actually easier to use than ICD-9-CM.

And the alphabetic index and electronic coding tools will continue to facilitate proper code selection. Just as you don't search the entire list of ICD-9 codes today, the search for the proper code—that's not how you look codes up on ICD-10 either, as I showed you with the coding examples earlier. And it's anticipated that the improved structure and specificity of ICD-10-CM will facilitate the development of increasingly sophisticated electronic coding tools that will assist in even faster and easier code selection.

Another question on slide 73: “Are ICD-10-CM code books currently available?”

And yes, they are, from—a variety of different code book publishers already have ICD-10-CM code books out there. And ICD-10-CM is also available free of charge in PDF and XML formats from the National Center for Health Statistics, with the link listed there on slide 73.

And “Where can physician practices obtain a list of ICD-10-CM codes applicable to their particular specialty?”

I would recommend contacting your medical specialty society because I think a lot of them have started working on that.

Resources

So, if you have a specific ICD-10-CM coding question, how would you get that answered? Well, the American Hospital Association Central Office serves as the U.S. clearinghouse for issues related to the use of ICD-9-CM and ICD-10-CM and PCS codes. And on slide 74, we've provided you with the link to the online process for submitting coding questions to them.

These coding questions are reviewed by an editorial advisory board comprised of a variety of coding experts and physicians, as well as the four cooperating parties that I had mentioned earlier, who publicized the official responses to these questions. So that's the process for submitting questions.

And please submit a copy of the applicable—the identified medical record with the coding question. It's very difficult to respond to coding questions without the medical record to refer to, just as you would find it hard to code a case without having the medical record to review.

This coding clinic process does not respond to payment policy questions, however. They just respond to coding questions. So for payment policy questions, you should contact the relevant payer, such as your Medicare contractor if it's a Medicare question, or the appropriate private insurer if it's a non-Medicare question.

On slides 75 through 78, I've provided some of the resources that AHIMA offers, including a link to our website. Many of these are free of charge, such as our Planning and Preparation Checklist. A lot of organizations, including CMS and many professional associations, offer a wide array of free, very comprehensive materials that I really encourage you to seek and use because a lot of them are just wonderful. And a lot of other groups, commercial entities, offer tons of educational materials and implementation resources, as well, to help you make this transition.

And so now I will turn it back to Leah for the question-and-answer session.

Special Announcement

Leah Nguyen: Thank you, Sue.

Before we start the question-and-answer session, we would like to make a special announcement.

CMS will soon provide a new opportunity for Medicare-enrolled providers and suppliers to give us your feedback about your experience with your Medicare Administrative Contractor, or MAC, the contractor that processes your Medicare claims. This new assessment tool is called the Medicare Administrative Contractor Satisfaction Indicator,

or MSI. Your feedback will help CMS monitor MAC performance trends, improve oversight, and increase efficiency for the Medicare Program.

Each year, CMS will randomly select its MSI administration sample from a list of providers who register to become a participant. If you would like to register to become an MSI participant or for more information, please visit the website listed on slide 80. Thank you.

Question-and-Answer Session

Our subject-matter experts will now take your questions about ICD-10. We have had tremendous interest in this call and may not be able to address every question today.

As a reminder, an audio recording and written transcript will be posted within 2 weeks on the MLN Connects Call website.

Before we begin the question-and-answer session, 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, Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Remember to pick up your handset before asking your question to 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 into the conference.

Please hold while we compile the Q&A roster.

Your first question comes from Jill Young.

Jill Young: Good afternoon. My question is regard to the episode of care, the A seventh digit. And it says it's for initial episode, but then in the descriptor it goes on to describe additional surgery and stuff like that. Are you going to clarify that any better? Because initial to me means, like, the first one and that's it. But it goes on to describe other events that would be included with that A.

Sue Bowman: This is Sue. I can answer that question. And yes, that's actually an excellent question. I'm glad you raised that point.

The word "initial" does sort of imply that it's only the very first time. But it actually is intended to be used as long as the patient is really still in the active treatment phase. And

the reason for that is a lot of patients, they'll go to the ED with the injury, they'll be referred to the orthopedist, who will then do the definitive surgery, and so forth. And it doesn't really seem like the orthopedist, who's actually repairing the fracture, is really a subsequent encounter just because the patient happened to go to the ED first.

So, the intent is that it would be the initial encounter as long as the injury is still undergoing active treatment and isn't like, sort of a followup kind of visit.

Jill Young: But it uses the words—shoot, I don't have it right in front of me, and I do apologize—"for removal of fixation," and sometimes, that requires going back into the OR, and all of that's going to be considered initial?

Sue Bowman: No. If they—if they go back in for removal of the hardware, that kind of thing, that could still be considered subsequent. It isn't necessarily limited to just aftercare. But anything that would be considered, really, the main focus of actively treating the injury to begin with, that would still be considered initial.

Jill Young: Will we get any clarification? I hear—I hear what you're saying, but I also see the gray area starting to creep in. Will there be any further clarification of that, perhaps from coding clinics or the hospital clinics or somewhere there?

Sue Bowman: We can—yes, I'm sure that there will be, probably, questions coming in to coding clinic for different scenarios to clarify that. So, yes.

Jill Young: OK. Great.

Sue Bowman: And if you have a specific case that you'd like to know about, of course, you can submit it to coding clinic on that slide 74 that I referenced.

Jill Young: Great. Thank you very much. I appreciate it.

Operator: Your next question is from Maggie Jazvic.

Maggie Jazvic: Hello. Again, this is Maggie Jazvic. I work with Cornerstone Prosthetics. My question is, is to try to get more clarification on the seventh character. We are a DMEPOS provider. We do a lot of cast changes after amputations, and bracing after fractures and also after surgeries. So would we be using that seventh character?

Sue Bowman: Yes. If you're—if you—well, I—you know, that would sort of depend on the actual scenario. But if you're using the injury code, you would be sort of the subsequent encounter, to follow up on the previous caller's question. Yours would be a perfect example of what a subsequent encounter would be because you're not, you know, actively reducing or—the fracture or anything like that. So . . .

Maggie Jazvic: Right. Right. We—the primary—or we would have a referring physician sending the patient to us after the, say, fracture. We would be giving them a brace. So then we would be coding with the seventh character.

Sue Bowman: Right.

Maggie Jazvic: OK. Thank you.

Operator: Your next question is from Robert Zeman.

Robert Zeman: Yes, hi. This is Bob Zeman. I chair the Carrier Advisory Network for the American College of Radiology. And my question is—I was glad to hear your comments about GEMs and mapping. As you know, for radiology referrals, we don't always get the most specific codes possible, and a lot of the local coverage determination policies that the carriers use are kind of a reflection of that.

I'm kind of worried, and I guess I'd want to know, what's going to be the process to make sure that the MACs are actually translating their old LCDs that have a lot of the ICD-9 codes in them into the newer policies with ICD-10 codes? Because, again, I'm concerned that there may be inaccuracies, there may be change in intent to the policy without vetting it through the Carrier Advisory Committee. So what's your take on that?

Janet Brock: This is actually Janet Brock.

Robert Zeman: Yes.

Janet Brock: I work in the Coverage and Analysis Group.

Robert Zeman: Yes.

Janet Brock: And we help oversee the policy direction for the LCD writers . . .

Robert Zeman: Yes.

Janet Brock: . . . here at CMS. Now, I cannot speak for the LCD writers or MAC leadership, although we've talked extensively about the plans that they have to translate their own policies. I believe that they plan—and they're doing it now, actually—to follow the same process that we followed for national coverage determination, which is to primarily, as the first step, use the GEMs, use the CTT tool developed by 3M, and then use clinical oversight to find and take out those codes that maybe are inappropriate according to the policy as written.

Robert Zeman: Yes.

Janet Brock: Because, of course, the policies are to be preserved.

Robert Zeman: Yes.

Janet Brock: There should be no change in coverage . . .

Robert Zeman: Right.

Janet Brock: . . . as part of this conversion.

Robert Zeman: Yes.

Janet Brock: If there were a need to change coverage, then the policy, whether it be national or local, would have to be reopened.

Robert Zeman: Yes.

Janet Brock: So, from what I've heard from the LCD writers, this is what they plan on doing. Because it is—just like with national coverage, because it is a conversion of present coding and not a change in policy, there's no need to actually put it through an advisory body. We didn't put ours through MEDCAC. We don't expect our local—our local contractors to put it through their CACs.

But just like national coverage, once it's published for you to see and if you see something that you don't agree with, I believe that the local contractors are looking for feedback, just like we're looking for feedback at the national level. They're going to have their codes out in front of the public 6 months in advance of them being active, you know, for the—for the transition to ICD-10 on October 1st, 2014.

Robert Zeman: Yes.

Janet Brock: There is time to make those changes . . .

Robert Zeman: Yes.

Janet Brock: . . . especially if a lot of people have something to say . . .

Robert Zeman: Yes.

Janet Brock: . . . about the specific changes. So I would say keep an eye open. I would say especially, talk to your MAC . . .

Robert Zeman: Yes.

Janet Brock: . . . if they happen to be a local jurisdiction. If you're a national provider and you work with several MACs . . .

Robert Zeman: Yes.

Janet Brock: . . . usually, it's best to come through up here. You can send a—you can send a note to me through our CAC inquiries mailbox . . .

Robert Zeman: Yes.

Janet Brock: . . . or directly to Pat Brooks through the link that was given in the—in the presentation today. And we can have our LCD coordinator kind of help figure out what's going on there. There have been a lot of questions about whether CACs should be involved. There's benefits and also rather hefty expenses in having CACs involved.

Robert Zeman: Yes.

Janet Brock: And in this era of very constrained resources, we're having to kind of, you know, do what we can with what we've got.

Robert Zeman: OK. But, that's great news, that actually there will be an opportunity to take a look at those before we're dealing with denials, basically. So that's great.

Janet Brock: Yes. I would say look for them starting in October. Most of the MACs—I think everyone has agreed to have them out by—I'm sorry. I said October and I meant April.

Robert Zeman: April.

Janet Brock: I'm looking at a calendar. I should never do that.

Robert Zeman: OK. Thank you.

Janet Brock: Start looking for them in April. You may see them sooner.

Robert Zeman: OK. Great. Thank you.

Operator: Your next question is from Joyce Quinn.

Joyce Quinn: Hi. My question is—I'm thinking he—it was kind of answered. So, the local coverage determinations and the national coverage determination—are they available yet with the ICD-10 codes? Or is that what you're saying—they're not going to be available until April?

Janet Brock: They won't be available until April. They're actually in the process of being translated now.

Joyce Quinn: OK.

Janet Brock: All the system changes are in place. That was necessary for—you know, for internal testing, things of that nature. So basically what we're doing now is we're catching up with what you might call the paperwork of it and making sure that the manuals and the coverage policies reflect what's been done in the systems.

We—the commitment that we have from our MACs is that they will put that information out on their website and in our LCD database by April 1st, 2014.

Joyce Quinn: OK. Thank you so much.

Janet Brock: OK?

Joyce Quinn: Thanks.

Operator: Your next question is from Joan Criscitiello.

Joan Criscitiello: Yes. Hi. I work for a podiatrist in New York. And I just have a couple of questions. The mappings and GEMs—could you kindly explain that to me? Because I am completely lost.

Pat Brooks: This is Pat Brooks. We post on our ICD-10 web page something called “General Equivalence Mappings (GEMs) and Reimbursement Mappings.” If you're working in podiatry, you probably don't need to look at that at all. We developed these mappings for people doing massive code conversions, people like—that are converting payments, like an insurer like CMS.

Joan Criscitiello: Oh, I see.

Pat Brooks: If you're doing—so, if you're doing massive things like that—I don't even know that you want to go look at them, but you can feel free to look at them on ICD-10 website. I agree with what Sue Bowman said. If you work in a specialty area and you want to know the impact of a particular issue on you, I would open the code book or look at those electronic files that are also on CMS's website. And I would simply look up the codes for common conditions and see how they are affected.

You don't need to learn about the GEMs or reimbursement mappings to do what you need to do. You're probably much better off simply following Sue's excellent direction of how to use the index to get to the tabular and find your correct code.

Joan Criscitiello: That sounds perfect. Thank you.

Operator: Your next question is from Francine Tobin.

Francine Tobin: Yes. How can we find out if our State is using the external cause chapter or not? And have they already designated whether they are or they're not? The whole issue of training—we may need to—we may be able to skip if our State isn't doing it.

Leah Nguyen: Could you hold on for a moment?

Sue Bowman: Well, this is Sue. And I can—and CMS can jump in and help if they want. But if you have not—if you have not been reporting external cause codes under ICD-9 and haven't received any kind of notification from a State agency or a particular payer that they're going to start requiring them any time soon, then it probably does not apply to you.

Francine Tobin: OK. Thank you.

Operator: Your next question is from Kelly King.

Kelly King: Yes. I work for an ambulance company. We do both emergent and non-emergent transports. Most of our patients we take just once, but we do have a few patients that we do take more than once. How would that seventh placement affect us between initial and subsequent encounters?

Sue Bowman: Well, if the—it would—it would pretty much work the same way. If the injury is new and this is their first transport for the injury, it would be the initial—the initial encounter. If you're—if you're not sure later on, you just know that it's an older injury and they're having repeated trips based on the information that you may have, which may be somewhat limited, you may be using the subsequent encounter because you wouldn't . . .

Kelly King: OK.

Sue Bowman: . . . necessarily know whether they were still getting active treatment. But you would probably know that this—either that this injury just happened or this is an older injury.

Kelly King: OK. That's what we figured, but we just wanted to double-check. Thank you.

Operator: Your next question is from Jackie Kravitz.

Jackie Kravitz: I'm so sorry. I had my microphone muted. This is Jackie Kravitz, and my question is about unspecified codes. The question that I have is, if I don't have enough information in the documentation, should I try and find it out first? Is that an automatic red flag and won't be payable? Or can I continue billing with that unspecified code?

Pat Brooks: This is Pat Brooks. That's a little difficult to respond to because we don't know the issue. But what I would say to you is if you work in a physician office now, and you know there is a payment edit on a particular service for a CPT code that requires extremely specific ICD-9 codes, then you can just assume that under ICD-10-CM, that they're probably going to have extremely specific edits for ICD-10 codes. And so you might need to get good information to document better.

If now, for the claims that you send in, you have more general diagnoses like pneumonia, you haven't been putting down the bacteria type or whatever and that's going through fine, then you can probably assume there aren't going to be new payment edits from October 1st, 2014, for pneumonia, and you might not need to ask your physician, "Are you going to go do testing?" and things like that. Like Sue said, you code what you know at the time.

And frequently in the physician's office, you're doing the first encounter. Maybe all you know is a general diagnosis. And maybe at the second encounter or later after testing, you might have more information.

So you code what you know. You don't hold up plans waiting for special tests to be run. But, you're aware that if there are payment edits for a small percentage of your claims for a CPT code, then, you may need to get more precise information on the diagnosis.

Sue, do you have anything else to add? That's the most generic advice I can give.

Sue Bowman: No. I would—I would agree. And I think it's important to realize that, you know, there's—while unspecified codes should be used when they're appropriate, there are places today, even under ICD-9, where ICD—where unspecified codes are discouraged or not included in the particular payment policy or an edit.

So I agree with Pat that you should just be aware of where those exist today in ICD-9 because a lot of those same areas is probably going to be the same situation in ICD-10, the areas where the payers are going to be looking for greater specificity. And as—and as Pat said, certainly, you shouldn't be going out and doing additional testing or anything trying to get to a more specific code. It should be what you know at the time of that encounter.

Jackie Kravitz: Thank you.

Operator: Your next question is from Ana Servellon.

Ana Servellon: Hi. My name is Ana Servellon with Care & Rehabilitation. We're an outpatient physical therapy office. And I was wondering, if we have a patient that is attending physical therapy prior to 10/1, we start reporting with an ICD-9, on 10/1 will we need to change it to an ICD-10 code?

Sarah Shirey-Losso: Yes. This is Sarah Shirey with the Provider Billing Group. And we have instructions. Since ICD-10 is based on date of service, for services performed on or after 10/1/14, you would use your ICD-10 code.

Ana Servellon: OK. Thank you.

Operator: Your next question is from Sue DeRosa.

Sue DeRosa: Yes, hi. I work for an optometric physician. Sometimes we get referrals on same day from a primary care's office. Is he allowed to do first encounter as well?

Sue Bowman: Yes. As long as you're both—you know, as long as the injury is still new and actively being treated and is often—that's often the case where multiple physicians are treating the injury at the same time. They would all report initial encounter even if it's the same day.

Sue DeRosa: OK. And just one other quick question. Could you just go over an inclusion term for me real quick?

Sue Bowman: An inclusion term—in a couple of the examples I had, there was—it just refers to some examples of conditions that are classified to that particular code. And it appears underneath the code number in the tabular part of the—of the coding system. So, it will just—like in the example I gave on slide 40, I think, on COPD, there was a bunch of terms for chronic asthmatic bronchitis, chronic bronchitis with airway obstruction—it gave a whole long list of terms.

Sue DeRosa: Yes.

Sue Bowman: Those are called inclusion terms because they're just saying that—those terms are examples of the conditions that are classified to that category or that code.

Sue DeRosa: OK. Thanks. I'm sorry. We don't have a computer up. We're just doing phone. So, I just needed a slide to refer to, then. Thank you.

Sue Bowman: Yes.

Operator: Your next question is from Sybil Kalish.

Sybil Kalish: Good afternoon. Thank you very much. I'm an independent medical educator. I'm still not clear about the initial encounter. As long as the patient is receiving active treatment for the condition—it's not really clear what that is. The patient is being treated for a broken leg.

Sue Bowman: So, as long as they are still receiving treatment for—to sort of repair or actively address the fracture, that would be considered active treatment for the purpose of assigning the initial encounter. If they are coming back to have hardware removed, to go to physical therapy, to just have the physician do an X-ray and check the status of the fracture to make sure it's healing OK, those would all be—or a cast change—those would all be examples of the subsequent encounter.

Sybil Kalish: So, then, I can bill an initial encounter when the patient comes in for surgical evaluation *and* as the diagnosis for the surgery.

Sue Bowman: Correct.

Sibyl Kalish: All right. That's where I was being tripped up a little bit.

Sue Bowman: Yes. The initial encounter can be used multiple times by multiple physicians, as long as they are still in the stage of their injury where it's actively being evaluated and actively being treated as opposed to being followed up or having hardware removed or, you know, other things that are going on after all of the treatment part has been done.

Sibyl Kalish: All right. Thank you for the clarification. I appreciate it.

Leah Nguyen: Thank you.

Victoria, it looks like we have time for one final question.

Operator: Your final question comes from Kim Riggs.

Kim Riggs: Hi, this is Kim. The question I had—and I'm not a coder, so I may not be—this may be a very quick answer. But, on page 59, it talks about the external cause code. And in the example, you have both “falling down on ice-covered steps”—so, the “ice-covered” and the “steps.” But we only did “due to ice or snow”—“a fall due to ice or snow.” Is it not important to include the “steps” in there? Or, when would you use one and not the other?

Sue Bowman: The—on that slide, the indentation did not show on the slide quite correctly. The “ice-covered” part is indented under “steps” if you actually look it up in the index.

Kim Riggs: Oh, OK. It's all inclusive?

Sue Bowman: So it's not—it's not an either/or situation.

Kim Riggs: OK.

Sue Bowman: It's, you look at the steps, and then indented under that is “due to ice.” So, that's a ...

Kim Riggs: Oh, OK, great. All right. Thank you. That was it.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 79.

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

Lastly, before we end the call, for the benefit of those who may have joined the call late, please note that continuing education credits may be awarded by professional organizations for participation in MLN Connects Calls. Questions concerning continuing education credits should be directed to your specific credentialing organization.

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

Operator: This concludes today's call.

-END-

