AAPC-CMS ICD-10 Code-a-thon
April 26, 2011
1:00 p.m. ET

Please note this transcript references the old October 1, 2013, ICD-10 compliance date.
The correct ICD-10 compliance date is October 1, 2014.

Operator: Hello, everyone, and welcome to today's ICD-10 Code-a-thon event. The event will now begin with an introduction from Alexis Johnston with Ketchum Public Relations.

Alexis Johnston: Thank you. Good afternoon, everyone. This is Alexis Johnston from Ketchum Public Relations, and I would like to welcome you to today's ICD-10 Code-a-thon event. In an effort to make sure that providers and other industry professionals are preparing for the transition to ICD-10, the Centers for Medicare and Medicaid Services (CMS), and the American Academy of Professional Coders (AAPC) are collaborating to bring you this event help you get your coding questions answered. AAPC Certified Trainers are ready to assist you and are looking forward to your great ICD-10 questions.

Before I get started, I just wanted to give you an overview of how today's session will run. If you take a look at the schedule slide up on the screen, you will see that we are going to kick-off the Code-a-thon event with presentations on ICD-10 from Denise Buenning of CMS and Rhonda Buckholtz from the AAPC.

Their presentations will be followed by a brief wrap-up where we will address some of the common frequently asked questions. Then we will start the online-only Q&A session with the ICD-10 trainers from AAPC. At that point, the audio portion of our session will end and the online platform will go-live.

To ask a question during the online Q&A, please select the Q&A button on the top gray bar and type in your question. The AAPC trainers will address your questions as quickly as possible.

Lastly, I want to let you know that during today's audio portion all phones will be muted so that you can hear the presentation very clearly. Today's presentations are also being recorded. The audio portion and transcript will

be posted to the CMS website at www.cms.gov/icd10, and I'll just give you that website one more time, it's – www.cms.gov/icd10, so they will be available on the website within two weeks. Please note that there are no handouts for the event, but all the materials will be available on the CMS website as I just mentioned.

AAPC is offering two CEU credits for participating in this Code-a-thon event, the CEU number is AAPC-0413110323-A, and I'll say that one more time. The CEU number is AAPC-0413110323-A. Attendees must stay for the entire time to obtain these credits.

If you need any assistance during this event, please call 1-877-283-7062; that number is at the bottom of the slide on the screen. Now I'd like to turn it over to my colleague, Lauren Hoffmann, who will introduce our first speaker.

Lauren Hoffmann: Great, thank you Alexis. I'd like to introduce Denise Buenning. She's the Director of Administrative Simplification Group at the Centers for Medicare and Medicaid Services, Office of E-Health Standards and Services in Baltimore, Maryland. Denise authored both the Agency's proposed and final ICD-10 Rules and her areas of responsibility include CMS' ICD-10 Program Management Office, HIPAA transaction and code set enforcement, and HIPAA Administrative Simplification.

She's going to be speaking to you today about why the transitions to ICD-10 and Version 5010 are occurring, what exactly is changing, who is affected by the change, tips on how to prepare, and the resources that are available from CMS.

So without any further ado, I will pass it on to Denise, to start the presentation.

Denise Buenning: Great. Thank you, Lauren, and thanks to everybody today who is joining us. Good afternoon; and for our colleagues on the West Coast, good morning.

This Denise Buenning with the Centers for Medicare and Medicaid Services, Office of E-Health Standards and Services, and I want to thank everyone today for taking time out to participate in this event. Particularly, I want to

thank the AAPC. When we first had this idea a number of months ago, they really jumped on it and developed it into the event it is today. As you know we had around 2,000 slots opened for this particular event and they quickly filled up, and I think it's just very gratifying that everyone has an interest in learning more about this. You know, we here at CMS we talk about this all the time, and we often think that perhaps everybody knows about ICD-10 and Version 5010, and you know, from the response that we've gotten today we know that that isn't necessarily the case. We are really excited about this opportunity to partner with AAPC, and use their coding expertise to get some of your specific coding questions answered.

So many times when we have these calls we don't have the time, or don't have the subject matter experts on hand to answer individual coding questions, so we will try and do a little bit of a general overview for everyone, to level the playing field as to why the transitions are being made, and then, again, when we get into our webinar section, deal with those specific questions. So again, our thanks to AAPC, Deborah Grider, Rhonda Buckholtz and all the other AAPC leadership for helping us with this.

Let's talk a little bit about what this is all about. The topics that we are going to cover today, that I think Lauren went over. What is changing, who is affected? Some of the key details about Version 5010, why we are making the changes, getting ready, important dates, and of course, resources to help you prepare, and there are lots of them out there. So exactly what's going to be changing?

Two different changes are going to be taking place. The ICD-10 Diagnosis and Procedure Codes are going to be transitioned from the current ICD-9 version over to ICD-10, and along with that, there's going to be a change in the HIPAA Standards, the current Version 4010 and 4010A1. They are going to be upgraded to Version 5010 and these standards are used to electronically transmit claims and other administrative transactions. Now I know that that sounds very technical, and perhaps to a lot of providers on the call, they may not recognize these particular terms, especially when it comes to Version 5010. If you ask providers if they ever sent an eligibility inquiry or a claim status inquiry, they know exactly what that is.

Version 5010 is basically what's under the hood. It's a software change that upgrades the systems to really bring it forward and accommodate a lot of the changes that had been necessitated by a change in industry needs. So we are talking about going from 9 to 10 on the International Classification of Diseases, and from 9 to 10 PCS. You will see currently that you have ICD-9, you have Volume 1 and Volume 2, and then Volume 3 was just basically your procedure codes, and we are breaking that out into ICD-10-CM, which is the diagnosis code, and ICD-10-PCS, which are your procedure codes. The Version 4010 and Version 5010A are the current HIPAA and they get upgraded here actually as of January 1, 2012.

So who has to do this? Anyone who is covered by HIPAA, and if you're a healthcare provider you pretty much know what HIPAA is. Health care providers who conduct electronic transactions like eligibility inquiries, health care – health claim status, payers, and that includes Medicare and Medicaid, they are the largest insurance group – if you want to call it that – in the world so we are also subject to the HIPAA provisions. Clearinghouses also are covered under HIPAA and they have to adhere to the HIPAA rules.

There are some non-covered entities that use the ICD-9 codes currently, some business associates, some vendors, workmen compensation programs, life insurance companies. The majority of the industry is changing over to 5010 and ICD-10, and while these non-covered entities aren't obligated, or aren't mandated to make the changeover, we've been getting anecdotal reports that they are going to accommodate the new code sets, just from a practical perspective. It was very difficult to have an entire health care industry using one set of codes, and some segments of it, nothing official, but we are getting anecdotal reports of inquiries being made and some of the workmen compensation programs, in particular, working toward making the transition to ICD-10.

So let's talk a little bit more about Version 5010 and ICD-10. Version 5010 replaces the 4010, and again, although you may not be necessarily familiar with the current standards, they are in use every day in the United States. These standards are really the platform or the foundation used in Practice

Management or other software that allows you to electronically send and receive information to and from a plan to verify eligibility, to submit a medical claim for reimbursement. Many professionals are familiar with the transactions but, again, not necessarily, the mechanism that gets it there, and as I said, it's always what's underneath the hood.

You don't necessarily need to know what's there, but you need to know that when you turn the key the engine works well. Version 5010 and 4010 are pretty much the same way. The new version is important for a number of different reasons, and the most important thing, at least from an ICD-10 perspective is that you cannot have ICD-10 without Version 5010. In Version 5010, for lack of a better description, is a toggle switch that basically tells the software and tells the systems you're using ICD-10 codes, but the format is a little bit different. So it's really important that Version 5010 is in place first.

Version 5010 fixes the deficiency in Version 4010. Version 5010 speaks to the deficiencies in Version 4010 – and a lot of these were caused by changing business needs in the industry, for example, Medicare Part D drugs – Prescription Drug Program. What the industry has been doing was kind of a patchwork approach. It was making a lot of workaround or quick fixes to try and make the standards work with the current business' for the industry, so when the updated version came around, the Version 5010, it accommodated a lot of those changes.

It also does a number of other things; it increases processing time and it will increase, or make more efficient office workloads, you will get more information back when you make an inquiry. So yes, there will be less time on the phone following up on where something is, or eligibility for a patient, and of course we all know that the less time spent on administrative types of transactions and procedures, the more time that could be spent in patient care, and it also saves costs. So we can't continue to use the Version 4010 and the 4010A, it lacks functionality, and most importantly for us it does not accept the ICD-10 codes.

So what's our implementation timeline for this? For Version 5010 all covered entities must be fully compliant by January 1, 2012 and that's just about six

months away, which is not a whole lot of time. What compliance means is that providers and clients need to be able to conduct the HIPAA transactions successfully. The compliance dates are firm, they're not subject to change, so as of January 1 of 2012, if we are not using Version 5010 then that is a noncompliant transaction, and most likely it will be sent back and asked for Version 5010 and will be rejected.

Medicare actually started accepting test claims at the basic Version 5010 in January. Now since that time there has been a second version of the Version 5010 standard that they call the errata versions. What happened with this was the standard development organization that was responsible for Version 5010, called X-12, started reports as people started using and testing and preparing for Versions 5010. But, there were some glitches, perhaps, a typo here, or a misplaced space there, and that made it difficult to use the standard so they accepted all of the maintenance changes, and they issued what they called an errata, and this month CMS Medicare fee-for-service started accepting both tests and production claims into our systems and we will continue to accept both Version 4010 and 5010 through the end of the year. Of course once we hit January 1 of 2012, we will accept only Version 5010. So it's important for us to test because that makes sure that all of your transactions will be going through smoothly, and that reimbursements will be coming back timely without any problems.

ICD-10 is the next transition that comes after Version 5010, and it provides the opportunity to accommodate new procedures and new diagnoses unaccounted for in the current ICD-9 code set. As I think most of you who are familiar with ICD-9 know, it produces only very limited data about patients' medical conditions and hospital procedure, and the space is really limited. We are literally running out of room, and most of you are probably familiar with the chapters of ICD-10 and, you know it got to the point where we've been putting cardiology codes in the I-sections and vice versa and that really slows down coding. If you're looking for a particular code, you've got to literally know where to look; it's not very intuitive at this point. Many of the categories are full, so the ICD-10 codes allow for much more space for expansion and considering all the advances that we have in terms of, now, laser surgery, arthroscopic surgery, the different procedures. Now we really

need to have that kind of expansion where we are given the kind of advances that we are looking at in medicine.

So it's not just a matter of expanding a field and adding your digits on, the expansion of the number of codes allows greater specificity and exactness in describing a patient's diagnosis and in classifying in-patient procedure. ICD-10 will accommodate newly developed diagnoses and procedures, innovations, technology and treatment, performance-based payment systems, more accurate billing. Now under ICD-9, according to a RAND study, only one in five hospital claims are paid completely without the need for additional questions or paperwork, and they're hoping that the use of the more robust ICD-10 concept, we will really cut down on that. In addition, we will have better data to improve the management of patient care to better describe the diseases. Now, we are the only big seven country that hasn't made the transition long ago to using ICD-10, and we are also the only country in the world that uses it only for reimbursement purposes as well.

So sometimes it's difficult to compare other countries' experiences with ICD-10 to our own, because each country has its own version and uses it for different purposes. But we feel, especially when it comes to tracking a pandemic, and being able to share health information across borders that this will really bring us into line with the rest of the world.

Your ICD-10 code, as I said before, consists of two parts, you have the CM for your diagnosis coding, and it now has laterality, it will describe left versus right, whether an encounter it's initial or subsequent, whether it's routine or versus delayed healing, union versus non-union. For example, if a patient comes into an office and is diagnosed with a brain tumor, the ICD-9 code would give you a general code for that particular diagnosis, but in ICD-10 it will give you a more specific diagnosis code by allowing you to choose between left and right hemisphere, and whether this is an initial occurrence or a recurrence. It's not that this is going to change the way a medical record is notated, because providers always provide, at best, a description of patients' conditions and procedures and treatments in the medical record. This just reflects better that detailed level of medical record notations. So

you're not writing to the code, you're basically coding to what's in the medical record already.

Another example, a patient comes in with an arrhythmia and needs to have a pacemaker inserted. ICD-9 doesn't have a code for a pacemaker, but the ICD-10 PCS code set gives you a distinct code for a number of different devices, and it isn't nearly as general as the ICD-9 code set. Now we are talking about a jump in the number of codes from approximately 15,000 codes in ICD-9 to about 150,000 codes in ICD-10 and I know when we talk about those numbers, people panic a little bit, they feel they're going to have to know all the codes. Well, right now if you're in a provider's office especially or in a specialty in a clinical area like cardiology or dermatology; you're using only a subset of the codes. It's very similar to a phonebook, all the phone numbers are there for you to access, however, it's like somebody who is only going to be using a couple of numbers, and the most frequently used codes are the ones that you're going to be putting on your super bills and on your cheat sheet, so to speak.

You won't need all the codes all the time, but they are there if you need them. The other important thing to note is that the CPT codes that are used for outpatient and office procedures are not affected by ICD-10 transition, so what you're going to see is ICD-10, especially the PCS codes that are used for in-patient hospital procedures only.

There are a number of tools that CMS has developed to help the industry and they can use them if they wish. The most important of these are what we call the GEMs, the General Equivalency Mappings. They're a crosswalk between ICD-9 and ICD-10 and there are forward crosswalk and backward crosswalk. You can look up an ICD-9 code and be provided with the most appropriate ICD-10 matches and vice versa. Just as you find multiple words in a dictionary, you'll find multiple definitions, depending on how the word is used, it's then up to the clinician to determine which of them was the appropriate match. Again, you're going from 15,000 ICD-9 codes, to around 150,000 ICD-10 codes, and in many cases there is one match to many matches, but only about five percent of the codes represent 80 percent of the most-commonly used codes. So again, you won't use every number,

every code, but it's nice to know that they're all there. The GEM is a useful tool, but when you're talking about a large volume of claims, you're talking about a pair having to adjudicate millions and millions of claims a year, it's not a substitute, it is a tool, so it's not a substitute for a system changeover to ICD-10.

The Affordable Care Act, which I think you all know with health care reform, requires the Secretary of HHS to tap the ICD-10 Coordination and Maintenance committee to have a meeting before January 1 of 2011, and the reason they ask for that meeting is that they wanted to get stakeholder input regarding the crosswalk between ICD-9 and ICD-10. They wanted to get as much public input as possible to make appropriate revisions for the ICD-10 codes that would be pretty much ready to go by the time of October 1, 2013, rolls around, which is the compliance deadline. And they've also made another stipulation. Congress put in the Health Care Reform Bill that the crosswalk should be posted to the CMS website as revised, based on public input and feedback. They should be treated as a code set for which the Secretary has adopted the standards, so basically what does that mean?

That means if you're going to use a crosswalk, the Affordable Care Act tells you that you should use the version posted to the CMS website, and that's really important. It's important because if we have plans or whoever else is doing proprietary crosswalk, then it's going to be very difficult for providers to know which particular version of the crosswalk they should be using from whatever payer they're trying to file a claim with. If we have a standardized crosswalk it's going to make things a lot easier and a lot more consistent to the industry, so that's why that tradition is in there. So again, if you choose to use the GEMs, you should only use the ones posted to the CMS website.

We are going to be updating changes to the codes sets, so I think all of you who are familiar with coding know that there are two updates made every year to whatever code it happens to be enforced at the time. We wanted to also make sure that there wasn't going to be a change in the code sets prior to the implementation that would require people – systems to change and coders to make changes as well. So there is going to be a partial code freeze to eliminate that kind of uncertainty and, again, this was in reaction to the

industry asking for at least a stop point that they could count on in order to get ICD-10 properly loaded into their system. So for the last regular annual update to both ICD-9 and to the current ICD-10 codes will be made on October 1, 2011.

The partial code freeze will last until October 1, 2014, and then you'll see regular updates to ICD-10 resume. There will be limited updates to both code sets on October 1, 2012, for both ICD-9 and ICD-10 and on October 1, 2013, for ICD-10 only. Limited updates will be reserved for addition of major new technologies and diseases only. There won't be any other changes allowed, again, trying to limit the numbers of changes so that everyone can go forward with a stable set of ICD-10 codes.

So what are we doing here at CMS? Obviously we have a lot of work to do because not only do we have to changeover all of our systems, we have to changeover and assist the state, our Medicaid agencies with making changes to their systems, and we also have to make policy decisions that may impact the industry. We have a Program Management Office here at CMS for ICD-10 and we've been working now for the past few years to identify all of the touch points here at the Agency and look at our internal policies and processes and see what the crosscutting issues are. Our ICD-10 Steering Committee meets every other week, and what we've been doing lately, and I think that this is really significant is we've gotten past the planning stages of ICD-10. We are really starting to work on the implementation of ICD-10 and we are starting to see change requests go out to our Medicare Administrative Contractors or MACs. We are starting to get input back from them as to what changes they feel their systems will need and how long and how much that will take.

We are starting to gather all of the questions that we get from events like this, from teleconferences, from jazz sessions with our contractors, from emails that are just submitted to us. There are policy questions that we need to make decisions on, and what we are doing is maintaining an internal log of decisions to be made. We've actually gone through the log this past month or so, and are starting to come up with answers to many of the questions that I know you all have regarding CMS policy. Once we get change requests issued

to our contractors, we will announce those decisions and our policies through our SAQs on the ICD-10 website, but we have to wait until that happens to make sure that our MACs don't have any question or determine that, perhaps there may be some contrary indications to what policy decisions we might be making. So once we get those CRs issued, we will start to post these things to the CMS website.

Transitioning to ICD-10 is a major initiative, and when we first started out on this it was compared to the Y2K Initiative. Well, as we have found out, it's bigger than that because it doesn't just affect the field or just the date, it really affects systems, business processes, manuals, and while with an organization as large as CMS we face all of those issues. No matter what size you are, if you're a small provider office, or a multi-physician practice, or a small community hospital – it's important to get organized early. This is not a change that can be made a month before the compliance date. This is not a change that is just going to be phased in, it's a one-time date where we basically throw the switch and everything changes over.

Given that, there are steps that everybody can take to prepare for ICD-10. You know, we talk about organizations attending management support and putting a structure in place, which is an ICD-10 Committee, and that's great if you're a larger organization, but if you're a small doctor's office in Kansas, call a staff meeting. Ask everybody where these codes are popping up in their own work, talk to your vendor, talk to your software vendors who are carrying your physician or your Practice Management software, ask them – when are you going to be able to deliver to me an updated software that we can start loading and testing?

Organize your organization's assigned responsibilities for people for certain tasks. Check with your professional associations to see what information they have available. Obviously, the larger the organization, the more complex. This doesn't have to be complicated, but you do have to pay time and attention to it, and again, we are finding that our ICD-10 website is getting a lot of hits – CMS – www.cms.gov/icd10 – no hyphen – and also the AAPC website, the association's website. We just did some research showing that the first place that the industry is going to their respective association's

website to get information on ICD-10, so that's going to be really critical as you move forward.

There is lots of information out there, please access it as early and as often as you possibly can. One of the things that I know is that providers who aren't necessarily professional coders will ask questions about training. When we did our proposed rule back in 2008, training was a major concern; how do we get everybody trained and to really go to the training. I know we have some suggested curriculum of the basics of what you should be looking for, and these are just some of the titles of clinical definitions, of workflow changes. How to code diagnoses in in-patient hospital procedures, it's important for any organization to identify what your staff training needs are going to be, relative to coding.

Identify the staff in your office, the code, and it may be physicians, it may be nurses, it may be medical assistants. Just because you don't have a title "coder" doesn't necessarily mean that you don't code. In talking to organizations like AAPC and others, the recommendation is to schedule the training six months prior to October 1, 2013, which is the ICD-10 compliance date. We thought that was strange when we first had this discussion because the sooner you get training the better; but, of course our friends at AAPC showed us the error of our ways. They recommended that, if you don't use it, you're going to lose it, and that's very true.

You can get your training a year out, but if you're not using the codes then you fall out of practice with them, and your early training may end up necessitating from refresher training. The recommendation from our experts is that there's a lot of training out there available through associations, online courses, webinars, onsite training, but do it around six months out. And again, if you're short on resources, you don't have the time or the money to be able to afford to send your staff to training, again, take advantage of online training, or collaborate together. Get a number of offices together - have one or two people go for training and then come back and train the rest; that can really help you stretch your training dollars and your resources.

Basically, here are the dates, plan ahead. January 1, 2011, providers and payers should already have started their external testing of Version 5010, and what that means is that during this time, they really should be testing with their payers, their plans, to see if what they have loaded in their systems work. Can they successfully conduct a Version 5010 transaction and have it sent back properly. While not too many are ready to test at that point now that we have the errata version of 5010 in place and Medicare people services started accepting testing production claims and test claims with Version 5010. I think you'll see a lot more payers that are starting to say that they'll be ready, so look, contact peers, find out when they're going to test and what they're going to test and how you can get that started.

On January 1, 2012, Version 5010 goes into full implementation. All electronic claims must use Version 5010 as of that date. Around a year and a half later, you've got full implementation of ICD-10, and that means any claims for services provided on or after October 1, 2013, must use ICD-10 codes only, there is no dual coding, you can't put an ICD-9 and an ICD-10 code on the same claim. If you submit an ICD-9 claim, most likely it will be returned to you and you'd be asked to provide the ICD-10 code. So again, don't wait until right before those dates, test early, test often, work with your vendors. You'll need the time in order to make sure that everything goes through smoothly.

Obviously any delays in these dates could really cause your organization problems in terms of workflow and in terms of reimbursement. So we very much want to make sure that all of these deadlines are met.

So just to recap – compliance deadlines and transitions are mandatory. There seems to be some rumors going on there that we would accept ICD-9 codes, on or after October 1, 2013, and that's not true. You just use ICD-10 after October 1, 2013. It's a big transition, the codes are structurally different, and again, it's going to take a lot of training and a lot of effort, but I think that in the end, considering all of the changes that it will reflect and will make a difference and the way health care is looked at, these are foundational really. All the other instances, notations they're coming around.

So again, important dates to have your plans in place, remember your dates; External Version 5010 testing, full implementation on January 1, 2012 of Version 5010, start your training on April 1, 2013, and then again, October 1, 2013 – full implementation. And again, on that date there are no phases. Also we've heard some other rumors that we were going to allow payers, providers that they were ready to start using ICD-10 ahead of time to do so. No, it really will create chaos in terms of all the other systems that have to be in place in order for that to happen. So we are sticking to the October 1, 2013, implementation, there is no phasing as there have been with some other HIPAA initiatives where you have a longer time for small health plans - no, everybody flips the switch at the same time.

Let's talk very quickly about resources. We've mentioned before the ICD-10 website, we also have a listserv that you can sign up and get free information whenever anything happens on the website that's updated. We have specific links to Medicare Free for Service Providers, Medicaid Programs, again, the opt-ins will feed your email updates, and we continuously update this website with new tools and information about the transition. In fact, we are going to be having some small provider, hospital, and some payer handbooks up there, hopefully in June, which will provide very simple directions of how to make an easy transition to ICD-10, so look for that in about a month-and-a-half or so.

Again, check your professional trade associations and see what's available on their website. Our industry updates provide subscribers with timely information. Here are some examples of what you'll see, you can opt in. I believe now we have approximately 30,000 people signed up for this, and it grows on a daily basis. Again, you will receive updates on all the information that changes and important notices and reminders of where you should be in the transition planning.

We also have a lot of fact sheets, these are the things that you can download, print off and share at staff meetings or a board meeting or just to use in your implementation that just gives you the basics of what you need to know and then refer you on to the website or other resources for more information. So these are great resources and you'll see they cover a wide

variety of things for medical practices, for transitions, what you should be asking your vendors; so, we keep adding to our lists as these are identified.

We are also running a bunch of advertising in national publications, and these are running in national publications like, you know, *Healthcare Economics*, *JAMA,* all the big publications, but we also made an effort to run them in state and regional publications like the *South Carolina Family Practitioner.* Just to be able to reach physicians to say, you know, this is coming, will you be prepared, here is what it means, and this is where you need to go for more information. So, we've been running these now for a number of months, and starting in June, we will also start running some more extensive online banner ads, and we will see how those go as well. Again, we're just trying to raise awareness out there, in the provider community as well as in the vendor community. The message to the provider community is ask your vendor. A message to the vendor community is, your providers are going to be asking – will you be able to respond?

So this has been a nice leveling field in terms of just raising general awareness among two key groups and that's pretty much what we had to talk about today in terms of CMS. My email address is up there in case anybody has any questions. Again, I thank you so much for your time today, I think this is a really important initiative, it's foundational to health care reform and it's foundational to meaningful use. It really ties into so many more initiatives that are going to be looking – if you look down the road in the future.

So I hope that you embrace it, I hope that you look at it enthusiastically and now I'm going to hand this off to Rhonda who is going to talk to a little bit about what's available through AAPC. Rhonda?

Lauren Hoffman: Yes, that's right, I'm just going to give a quick update – give everybody some information about our next presenter, Rhonda Buckholtz, Vice President of Business and Member Development, at the American Academy of Professional Coders. She has more than 20 years experience in health care working in the reimbursement, billing and coding sector. Rhonda is a lead member of AAPC's ICD-10 Training and Education Team, which is charged

with the development and training of curriculum on ICD-10 implementation and preparation for providers facilities and health plans.

She has developed training models for ICD-10 CM, for all specialties for the AAPC and is responsible for all ICD-10 training and curriculum development for the AAPC and the new Certified Professional Medical Auditors Credential for AAPC.

Rhonda is going to discuss complex diagnosis coding examples, best practices and ideal training for ICD-10, as well as the tools and resources available from AAPC, to help assist with the transitions. Rhonda?

Rhonda Buckholtz: Thank you. As Denise indicated earlier, one of the largest transitions that we have is going to be the jump in the sheer number of codes. In an ICD-9 CM, we have about 14,000, and it's going to jump our transition to 69,000 – just slightly over 69,000 on October 1, 2013. And as coders, that's the biggest sticking point on our heads, but this code set and the actual portions of it that we are going to be using is just one actual small chain in the link of events that need to happen in order for us to be successful in ICD-10 transition.

So this presentation is actually going to go down through the physician process, and all of those areas of impact. Of all of those changes that are going to need to happen. Then we will get into some of those changes where you're going to see some format and structure changes with ICD-10 that we can keep in mind for you. We do believe that it is too soon to learn the code sets. However, it will format the structure, and having general understanding is really important for us as we move forward and make that transition.

So the first thing that I want to talk about is the physician's office, and the map that we have that's available. So we are going to start in the manager's office, this manager is going to get hit hard and all of us in our own departments are going to be hard hit and really have to work toward making the transition. But, the manager is going to bear a large brunt – or a large responsibility of it. You're going to have to take a look at your new policies and procedures, but basically any policy or procedure that's tied to a

diagnosis code, your disease management tracking, your PQRI, any of those processes that you have internally are now going to have to be rewritten, revised, and reformatted for ICD-10.

All of the contracts that you have in your practices need to be evaluated whether they be vendor or payer, and updated, as needed, to make this transition. So with your health plan contracts if you have any type of language that's tied into them, regarding reimbursement and the disease process or diagnosis, you need to reevaluate those as well. Vendor contracts, making the transition over to ICD-10 in what they can and can't handle, and how that's all going to come into play; all of that of course, is also going to require budgeting.

Anything that we do, any software updates, training, education, new contracts, new paperwork, somehow has to get paid for. So now, this is one of those times that we really need to have a long-term budget in our practice and health care. I usually make the joke that in smaller practices, often times the process of a budget is whatever we happen to have in their bank accounts at any given moment. We need to actually think strategically through this and figure out where we are going to have to spend our money over the next several years in order to have ICD-10 implemented successfully. Of course on top of that, we are going to need to have some type of training timeframe, because basically every single person in your practice is going to need some type of ICD-10 training. Whether it's a slight overview of the changes that are coming down along the way, or as you go down through with your coders and billers, the more intense coding training. You need to determine how much training everyone in your practice is going to need and then how are you going to get it done?

The next area that we are going to hit is our clinical area. Our clinical area is going to see the majority of the changes; they are going to see changes to patient coverage. All of the health plan policies, payment limitations – all of those types of things that are tied in, are going to need to be changed. New order forms for any diagnostic test that we order; any labs, X-rays, things along those types of lines.

ABN forms may need to be revised as they go down along the way, you're going to have to take a look at them and see how you have your setup, because your policies and procedures regarding when you're going to issue those are going to have to change to meet the new policy limitations that will be out there.

Super bills, think about whether you're in an electronic world or a paper world; all of your super bills, no matter what, are going to have to be revised. Depending on the practice that you're in, the paper super bills or encounter form may be impossible for us to transition to leaving the diagnosis codes on. There have been a lot of different practices that have actually taken their normal two-page super bill, which is one page front and back, where there's one page devoted to a diagnosis code, and suddenly it's easy to expand it to, you know, five, six, seven, eight pages. Obviously that's not a way to conduct business in the future, and we are going to have to find out how we can make that transition if we are going to stay with paper super bills, and how are we going to revise those. So these are all strategic areas that we are going to have to take a look at.

Our health plans, of course, are going to revise all of our policies, that are linked to our local coverage determination or national coverage determination, those types of things. Those forms are going to have to be reformatted and patients are going to have to be educated to the changes that are going to come down along the way.

Next we are going to transition to the physician, there's going to be a greater need for specificity. It's going to increase dramatically with the use of ICD-10. Physicians are going to have to document laterality, stages of healing, weaks pregnancy, episodes of care, and other instances in ICD-10 where we are going to make those transitions. And when we say that changes to documentation needs to occur, it's not because we see or we feel that physicians are poor documenters, it's because the concepts have changed in ICD-10. They're going to have to make sure that they now capture those nuances that are found in ICD-10 to make sure that they can actually, accurately assign an ICD-10 CM diagnosis code.

And our code sets are actually going to grow to over 140,000 now – that if you include ICD-10 PCS. So the physicians have to be trained on where those changes are going to occur and what needs to be included in their documentation.

And the nurses' station, we have retained this to our forms. So think about that, every single order form that we have has to be changed, or completely redone, or reformatted. The nurses are going to need to make sure that they document with the increased specificity that's going to be required to make sure that all changes can be captured. And I'm sure there will be changes to prior authorizations coming down along the way. All of this policy is on the prior authorizations that are going to change to fit the new diagnostic codes. So it's going to require training and updates to all of the forms that are going to be out there.

Labs are going to see significant changes. Often times, especially in outside laboratories, we don't give them enough information in ICD-9 for them to be able to process the claims and that results in numerous phone calls back and forth. Changes are going to be needed to be made because now it's a higher level of specificity; the labs are going to need to make sure that they gather that information and that we, on the physician's side, give them those. There probably will also be new requirements for the ordering and the reporting of services as health plans go down through, and revise their policies and procedures, and update them for ICD-10-CM. Our billing and our coding are going to be significantly impacted. All payer reimbursement policies tied to any type of diagnostic medical necessity reasoning is going to have to be revised to fit ICD-10-CM.

The billers are going to have to be trained on the new policies and procedures for ICD-10 CM, and we are going to have to run dual systems for quite some time. Now as Denise indicated before, the transition to ICD-10-CM is included as part of the HIPAA Standards. Now there are certain entities which she indicated that aren't covered by HIPAA, workers comp is one of those. So for workers comp this is actually going to be one of those transitions where it's going to be state-by-state, carrier-by-carrier. So some states have some protections in place already where workers comp is forced,

or encouraged through law to adhere to the HIPAA Standards. Not all states have those policies and procedures in place, so there is going to be the need for dual systems, which means your coders and billers are going to have to run in dual systems for a period of time until everyone makes the transition.

There is nothing to say that workers comp has to make that transition. So you want to check and start looking now strategically, to see what kinds of plans they have in place to make this transition. If you're participating on panels, you will want to know ahead of time, because this is going to be an administrative nightmare. You are going to want to make sure that, you know, they know what plans they need to bill ICD-10 CM with and ICD-9 because you will want to make sure those claims go through, so that they accept them right on the first time.

Again, with our coding, we know we are going to transition over to the code set. So we know there is going to be changes in the book, like Denise said, it's a big book, but you're not going to use the entire book. So for most of us that are in a limited specialty, we might only use a portion of the book; however, that doesn't mean that we are not going to have some changes that come down along the way that we are going to have to learn. There is a lot of formatting and structure that is different in ICD-10-CM than it is in ICD-9. Because of the higher level of specificity, for those coders that don't have a strong understanding of anatomy and pathophysiology, they might need a refresher on some courses that will help bring them up to speed with a higher level of specificity that's found in the new code set. And keep in mind that they are also going to have to code into dual systems, for some period, while everyone makes the transition outside of the covered entities.

Even the people who work your front desk are going to need some type of training. For those practices that might have been very detailed in their HIPAA privacy policies, they might need to be revised and patients are going to have to sign new forms. It really depends on the structure and how far in-depth you went with your HIPAA privacy notice. Updates will more than likely be required by your systems and that may mean training on new ways of handling patient encounters, and taking a look down too along that way as well. Another thing, when you're talking about the waiting room is that

patients will need to also be educated, because this transition will affect them and their coverage as well, so that might fall along on the people at your front desk as well. So they'll need to have an understanding of ICD-10 and what changes, so that they can give a brief explanation to the patients that come down along the way.

So there's your briefly, just a very easily identified areas of impact in a physician's practice, and those are the steps that you need to start looking at in those key areas, because implementation is really what we should be focusing on now; however in order to successfully implement, we do have to have a good understanding of the codes and how they interact and relate.

So I'm going to go over a few slides that are going to show you some of the differences in the translations so that you can have a good understanding of what will be coming down along the way.

First and foremost, let's talk about diabetes. There were significant changes to the diabetes coding, and the majority of the codes are combination codes. So, we actually have six diabetes categories in ICD-10 CM right now. So we have E-08 for diabetes due to an underlying condition; E-09 for the sub-category for drug or chemical-induced diabetes; E-10 for the type one; E-11 sub-category for a type two; E-13 for other specified; and E14 for unspecified.

Now the thing to keep in mind with our diabetes is with the combination codes, we should actually have to use less codes, to actually explain our encounter or the patient's condition. In ICD-9 CM, usually we need two or three codes in order to complete the encounter with the use of the combination codes. In diabetes, you will see that a lot of times you can use fewer codes. So diabetes codes were expanded to include the classifications of both the diabetes and the manifestation, and so the terms and the codes have actually been updated to reflect all of the current clinical classifications that are out there on diabetes.

Diabetes is no longer classified as controlled or uncontrolled, and we give you a couple of examples here. We have E08.22, which is diabetes due to an

underlying condition with diabetic chronic kidney disease. An example there of good combination codes; E09.52 drug or chemical induced diabetes elements with diabetic peripheral angiopathy with gangrene. So you can see where we give you some examples of the diabetes codes that are in there as well.

The other thing to keep in mind is that for anyone that has been on long-term use of insulin, there's also a secondary code that we have to report with our E-codes as well, and that would be Z79.4 for the long-term use of insulin.

Now we talked about combination codes a little bit with our diabetes codes, but the combination codes extend well past that chapter. Because ICD-10 consist of greater specificity, we do have the availability of combination codes that are out there, and this is a hard concept for some people to grasp when we talk about the combinations codes, of having to use less codes, or fewer codes on our encounters, because when you think about going to 69,000 codes, you automatically think that it's such a difference from the 14,000 that we are using. A lot of times in ICD-10 CM we can actually use fewer codes to capture the encounter, and the true intent of what the patient was being seen for.

Now this slide just actually shows you a couple of other combination codes that are out there that requires a level of greater specificity, so we have I25.110 which is arteriosclerosic heart disease of the native coronary artery, with unstable angina pectoris. K50.013 which is Crohn's disease of the small intestines with a fistula, so now you can see actually with our Crohn's disease we actually have the manifestations or the other issues that are going along with it to – combined into one code. Then we have K71.51 which is toxic liver disease with chronic active hepatitis, that’s captured in there as well.

Now think about this, in ICD-9 we only have one code for complications of a foreign body that’s accidentally left in the body following a procedure. In ICD-10 CM we have 50 different codes for this that are available. So you can see where that’s expanded on, and this example just gives you some different scenarios that are out there. T81.535 which is perforation due to a foreign body accidentally left in the body following a heart attack. We have T81.530

which is accidentally left in the body following a surgical operation. Then you can see where we go down, where we actually have one that's following – or this is actually an obstruction T81.524, obstruction due to a foreign body accidentally left in the body following endoscopic examination. We have T81.516 which is the adhesions due to a foreign body accidentally left in the body following aspiration puncture or other catheterization. So these were greatly expanded to allow us to actually capture the detail of those complications.

Another big change that you're going to see along the way is the coding of our fractures. Our fracture codes actually require a seventh character to identify if a fracture is opened or closed. The fracture extensions are listed here below and so it's actually – A is for the initial encounter of a closed fracture, B is the initial encounter for an open fracture, D is subsequent encounter for a fracture with routine healing, and then we have G for subsequent – for a fracture with delayed healing. K is a subsequent encounter for fracture with non-union, P is subsequent encounter for a fracture with a malunion, and F is for sequelae.

Now keep in mind these extensions, the seventh character extension can actually change within the different sub-categories, so you always will have to refer back and make sure that you check your seventh – we used to say seventh digit – check your seventh digit – we will now have to say check your seventh character because of the half-a-characters that are contained in it. But, you can see we have a displaced fracture of a shaft of the last clavicle, initial encounter for a closed fracture S44 – S42.022 we need that seventh character captured so the code now becomes S42.022-A.

Here is another example that we have for you. A patient underwent surgery for an open burst fracture of the lumbar vertebrae which became unstable. So, in this example we have S32.012-B and that seventh character B in the sub-category actually identifies the initial encounter for the open fracture. Here is where we can get into some greater level of specificity, so think fracture of a clavicle. A clavicle is really just one long bone. We had one choice for it in ICD-9 CM; we have 24 choices for fracture of clavicle found in ICD-10. So, in this instance our documentation has to include laterality,

whether it's displaced, anterior posterior displacement, or non-displaced. The location, is it the sterna end and the shaft the lateral end, or is it unspecified. We will often need a seventh character extender, which in this example could be either A, B, G, K, T, or S. So for an example of the anterior displacement fracture of the sternal end of the right clavicle initial encounter for an open fracture, we have S42.011-B.

For the malignant neoplasm of the breast, when we talk specificity, there are actually 54 choices found in ICD-10 CM for both the male and female breast. So our documentation actually has to include laterality, the location or the exact site, the use of an additional code to identify estrogen receptor status, and we give you an example there of the malignant neoplasm of the upper outer quadrant of the left male breast, so an ICD-10 CM – now keep in mind the codes are in draft format, but the code now is C50.42-Q.

For our large and small intestines, we actually have 26 choices available, and our documentation actually has to include the specific site, and you can see that I have listed all of the different sites that are covered under ICD-10 such as appendix, cecum, colon, rectum, and then we go down through to the jejunum. So, in our example we have a malignant neoplasm of a splenic flexure and a C18.5 in ICD-10 CM.

Now I'd like to use the example on this slide, it's a really good example of – the physician has good documentation here, but the concept has changed in ICD-10 CM. So you can see where we have that – it's a foreign body in the nose, and the patient is a three-year-old who comes in after having put in a raisin in her left nostril, and her grandma was unable to remove it. And so the physician documents, the raisin was grasped with the forceps and removed, and examination of the nostril fails to reveal any further foreign body or problems.

Now in order to code this in ICD-10 CM, and I have this slide up here to show you just an example, you can actually find this example on the AAPC website under our code translator, and basically all we've done is taken the GEMs file that are available through CMS and put them in a user-friendly format so that you don’t have to search through all of the text. So you enter the

diagnosis code which in ICD-9 was 932, and it will crosswalk you over to some of the different scenarios. Now keep in mind that GEMs won't give you all of the matches that are out there, or all of the examples that it will show you. I really like this example because you can see an ICD-10 CM, I actually have two choices.

So now I need to know whether or not the foreign body was in the nasal sinusor in the nostril which we had the documentation of. I'm also going to need a seventh character extender, and so here it shows just the initial encounter, but is it a subsequent, for those of you who have worked in ENT practices or along that line, sometimes a physician isn't able to get it on the first attempt. And sometimes they have to go back or put them under – so you have to kind of take a look at those types – different types of scenarios and see what the actual encounter was: Was it initial? Was it subsequent? What was the encounter?

I also like this example because you can see the actual code for that, which is either T17.0 or T17.1, there are two X's that you see are considered dummy place orders in ICD-10, and that's how we can keep the code integrity and actually put that seventh character extender. So in these code situations where we don't have seven characters and we need that seventh character extender we have to use a dummy place order to order – to keep that code integrity in place and keep it together.

So let's talk a little bit now on what you can do now to begin to prepare for ICD-10, as Denise said, this isn't a quick fix. ICD-10 is going to take a lot of time and effort in our practices, and we have a lot of competing things going on in our practices that are getting our attention now, with EMRs, stimulus monies– things coming down in the HITECH Act and those types of things that are kind of competing for our ICD-10. We want to make sure that we keep ICD-10 on the forefront and begin to work with it and integrate it with all of those other areas that we are working on in our practice.

So at the AAPC we have what we consider 16 steps for a successful ICD-10 implementation. So your first step is really going to be to organize your implementation efforts. If you're in one of these larger practices, this is

where you're going to get your committee together and you're going to take a look at what's going on down the line; if you're in a smaller practice it might just be you and the doc. Then you're going to move on and you're going to develop your communication plan, again, when you're in those larger practices the communication plan is very important, and in a smaller practice this could be a simple staff meeting, a meeting with the doc after hours or before hours, whenever you can get the time.

You're going to conduct your impact analysis. Now for those of you guys that work-in-practice management or have ever done some type of practice management review in your in your office. This is where you're actually normally we would take the patient and we would follow the patient the whole way through the office, and basically find out where you have doubt, where things are falling down, where everything has been touched. You're going to do the same thing with that process, only now you're going to replace the patient process with a diagnosis code. You're going to actually take a 360 degree review of your practice and figure out where a diagnostic code, impacts or touches your practice, and that's going to be your impact analysis.

Then you're going to organize, especially if you're in as large a practice as your cross-functional efforts or in the smaller practices the steps would not be necessary. You're going to work on your budget development, and the budget development is going to be important no matter what size practice you're in. For your internal systems design and development, keep in mind if you use an outside vendor for your for your IS, or your IT, you want to make sure that you're on their timeframe, and that they have a good understanding of what's going to come down along the way with ICD-10. This is one of those areas where if you use external forces, you want to make sure that they're going to be available for you when this change happens, and develop your training plans. You're going to contact and work with your system vendors and make sure that they're on track for everything.

Then you're going to begin your implementation planning. Step 10 is your phase-one training. Now phase-one training is what we refer to as you are going on the fundamentals of ICD-10. You are going to learn the format and

structure, and history, how the code sets interact, those types of things, but you're not going to learn the code sets in-depth. Then you're going to take a look at all of your business processes and how those interact in your practices.

Phase-two training, this is where Denise said, you know, you don't want to get it too soon. You want to wait until six or nine months before implementation. This is where you're going to get your specialty specific code set training, where you're really going to become very familiar with working with your code sets. And you will want to make sure you take that training just in time because it's true, if you're not using it you're going to lose the knowledge. You will want to make sure that you can work with it and that you continue practicing with it, after you've learned it in-depth. Once you get through those phases, then you've got to take a look at all of your policies and whatever changes might need to be made to those and down along the way.

It's really important that anytime we implement such a large change, which ICD-10 is going to be one of the largest changes to ever hit health care, that we have some way to measure the outcomes. Is it what we expected? What improvements do we need to make? Those are the types of things that come down along the way.

Step 15 is really just that deployment of the code, so any changes that we need, any vendor solutions that we are going to use, this is when the vendors are going to give it to us and make sure that it's in a user-friendly format, and then we are going to do our testing and make sure that we can do work with their fields and all of that, that comes down along the way.

And of course, step 16 is going to be our go-live; our implementation compliance date which, of course, we all know is October 1, 2013. Now AAPC has a lot of resources that are available on their website, we have lots of news articles, frequently asked questions where you can go in and find information. We have our code translator which uses the GEMs codes to take your ICD-9 codes to what selections might look like in ICD-10. We also have a benchmark tracker that's available. This benchmark tracker is a really

important tool for you because it goes down through the 16 steps with check boxes so that you can go down along the way to make sure that you strategically hit that October 1, 2013, go-live date. And this is just a sample of what our benchmark tracker is, so you click on any of those steps and then that will give you what all – you should be doing during that step, and you can check it off, and then that's what's going to change the colors for you. Green means you're good to go, yellow means you're cautioned, you're falling behind. And red means that you're really behind and you really mean to step it up in order to get your compliance in.

We also have training options that are available out there, we do not have cassette available as of this time because it's not time. The focus should now be on implementation of ICD-10 in your practices. And of course, we have resources that are out there, we do have links to the CMS website, they have great resources that are out there. As Denise mentioned, you will want to make sure that you always go to your trade associations, your doctor's associations that you belong to, your state medical societies, and those types of things, to see what they have in mind and how they can help you prepare as you go down along the way.

And Alexis, that's the end of my presentation, if we want to start.

Lauren Hoffman: Great, thank you Rhonda and Denise for your incredibly informative presentations. Again, I just want to just give a quick reminder that the presentation, transcripts and audio, Q&A, will all be available on the CMS website within two weeks following this presentation.

Before we begin the online Q&A with the AAPC trainers that are available, I'm just going to go ahead and cover off on a couple of frequently asked questions, so I just – I'm going to jump into that with Denise and Rhonda. Is there any possibility that the transition date for ICD-10 will change at all?

Denise Buenning: Hi, this is Denise, I can answer that. Right now we have absolutely no reason to believe that the dates are going to change on either 5010 or ICD-10, those dates are firm, again, January 1, 2012, for 5010; and October 1, 2013, for ICD-10.

Lauren Hoffman: Great. Thank you. Are there any provider groups who will be more affected than others by the transition to ICD-10?

Rhonda Buckholtz: This is Rhonda. There are some provider groups that will be affected more, family practice or internal medicine because they use a larger sub-section of the codes. As well as orthopedics, cardiology, those are practices that have some changes that are coming down along the way that require a higher level of specificity in a different way, more intense use of the code sets – so they would want to take a long, hard look at the impact.

Lauren Hoffman: OK, great. Now there's a lot of competing priorities for health care providers right now with the HITECH Act among a whole bunch of others, why do providers need to make sure that they still keep ICD-10 kind of on their radar, on their agenda, and really start planning?

Denise Buenning: This is Denise I can take that one. As I think I mentioned before, when we first developed both Version 5010 and ICD-10 regulations, a lot of the initiatives that we are looking at now such as meaningful use of – and some of the other regulations that are coming through the system, were not even, a tinkle in their eye, so to speak, but I think that there are couple of things that are really critical to remember. Number one, they are mandatory, it is not an either or, this is by regulation and we have to adhere to it.

Number two, these are foundational. You can't have really meaningful use without the kind of robust, patient-encounter information and data that the ICD-10 code sets are going to generate. You're not going to have administrative simplification and streamlining of a lot of the business processes of health care that can really save the industry a lot of money if you don't have a system like Version 5010, that really provides more robust information and gives people upfront the information they need, so that they're not calling back the plans, they're not spending time on the phone, they're not having to resubmit more information. So a lot of this is coming down all in a very short amount of time.

The first one out of the gate is 5010 and ICD-10 and they really will help further down the line as we get more into carrying out Congress' intent to really streamline the operations of the health care industry, and to use the resources that we are currently spending on that segment of the industry and putting it more toward patient care and making it better for providers and for payers to get reimbursed fairly and properly and timely.

Lauren Hoffman: Great, thanks, Denise. Participants, we are now ready to move into the Q&A portion of the Code-a-thon. If you look at the current slide, you will see some instructions for asking questions, so I'll just kind of walk you through the process.

You select the Q&A tab at the top of the menu bar in gray, type your question, click "Ask" and then an AAPC trainer will then take your questions. You will see a couple of popup here, notifying you that your question has been answered.

Please keep in mind that the same AAPC trainer who answered your first question may not be the one who answers your follow-up question, so just be sure to try to explain your question in detail as necessary, and then throughout the whole session, the Q&A session, is going to follow this audio portion, you will be able to see answers to questions asked by your fellow attendees on the Q&A tab. So please feel free to review that to see if, maybe, your question has been previously answered, or just kind of feel free to watch the Q&A happen and kind of soak in all of the information.

Again, we will be posting the slides, the audio, transcripts, the Q&A, to the CMS website in about two – within about two weeks, so feel free to check back for all of the material.

So at this time of the presentation, our audio portion is going to conclude, the web portion will remain live for online Q&A. As I mentioned you'll be able to type your questions, and you are now free to hang up your phone, and start typing your coding questions, and the AAPC trainers will be answering them as soon as possible.

Thank you all for your time, and again, feel free to check the ICD-10 section of the CMS website for the audio, the slides, the transcripts and the Q&A.

Thank you so much.

Operator: Ladies and gentlemen, thank you for participating in today's conference call, you may now disconnect.

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