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Centers for Medicare & Medicaid Services

Basic Introduction to ICD-10-CM National Provider Call

Moderator: Ann Palmer

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Part 1 of 2 Audio Recordings

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Welcome and ICD-10 Overview

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Operator: Good afternoon. My name is Chrissy, and I will be your conference operator today. At this time I would like to welcome everyone to the Basic Introduction to ICD-10-CM Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star, then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you. Ms. Ann Palmer, you may begin your conference.

Ann Palmer: Thank you. And as Chrissy said, I'm Ann, and I'll be moderating today's conference call. Please note that this call is being recorded and that the written and oral transcripts will be posted shortly. You can find call transcripts and discussion materials for this conference call by visiting www.cms.hhs.gov/icd10 and selecting CMS Sponsored Calls on the left side of this web page. Our first speaker is Pat Brooks, who is senior technical advisor at CMS. She is going to provide information about the requirement to report ICD-10-CM/PCS codes for services provided on or after October 1, 2013, and that ICD-9-CM codes will not be accepted after October 1, 2013. Go ahead, Pat, please.

Pat Brooks: Thank you, Ann, and I want to welcome everybody, and I'm glad you're all participating in this basic introduction to ICD-10-CM. And I do want to acknowledge Sue Bowman, our next speaker from AHIMA for all her efforts in developing this overview, this basic information of ICD-10-CM, which is the diagnosis part of this coding system. And for those of you who have not found it, the website does have the slides that we're following along

today. And in addition, there's a very helpful document called a Quick Reference Information so that for some of you who have heard this call and would like to perhaps brief other people that you work with in your company or organization on the basics of ICD-10-CM, that Quick Reference Information Guide should be useful to you to explain very elementary things about the new coding system.

But I'll turn now to the implementation of ICD-10, and if you'll look at slide three, you'll see that on January 16, 2009, we published a final rule that requires the implementation of ICD-10. And that final rule requires a compliance date of October 1, 2013, for the implementation of both ICD-10-CM, which is the diagnosis section, and ICD-10-PCS, the procedure section. And those of you who would like to read that final rule, I do provide the link on slide three where you can get additional information.

Moving on to slide four, I'll discuss a few important facts about ICD-10 implementation. First of all, is that there is a single implementation date for all users. I must stress quite strongly that October 1, 2013, will be the date that everyone will begin to use ICD-10. So if you were working in an ambulatory care center or a physician office and you see patients on October 1, 2013, on that date you must start coding your diagnoses in ICD-10. If you were in a hospital inpatient setting, for patients discharged on or after October 1, 2013, that will be the date that you must begin using ICD-10 codes. And to stress this it the other way, ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013. Now, we do acknowledge that some of you may be coding bills that are a little after the fact, and say for August, maybe you do not submit bills until October or November. And we do know that payers will be receiving ICD-9 codes for over a period of time. But they will be ICD-9 codes for services prior to October 1, 2013. And one last important bullet point, the bottom of slide four is there will be no grace period. In other words, we will not be slipping the date beyond October 1, 2013, for ICD-10 codes. And this will be a compulsory implementation of these systems. Thank you.

Ann Palmer: Our next speaker is Sue Bowman, who is director, coding policy and compliance, at the American Health Information Management Association. In her role as one of the ICD-9-CM Cooperating Parties, she will be presenting today. The Cooperating Parties represent a long-

standing public and private sector partnership between AHIMA, CMS, the American Hospital Association, and the Centers for Disease Control and Prevention. Please note that CMS does not endorse outside organizations' materials or activities. Sue is going to provide information about the benefits of ICD-10-CM, key similarities and differences between ICD-9-CM and ICD-10-CM, general structure and characteristics of ICD-10-CM, new features in ICD-10-CM, setting the record straight about common ICD-10-CM myths and misperceptions, and impact of ICD-10-CM on medical record documentation. Go ahead, Sue, please.

Sue Bowman: Thank you, Ann. And before I get started talking about ICD-10-CM, I was asked to mention that if you have an AHIMA credential in which to claim CEUs for today's program, today's 90-minute program, it is worth 1 CEU. Simply report the CEU for this program as part of your AHIMA CEU reporting cycle and maintain documentation about today's program, such as this slide presentation, in case of an audit. For additional information about AHIMA's CEU requirements, you can find a Recertification Guide on the AHIMA website. For those of you who may be credentialed by other organizations and you're not sure of the CEU reporting requirements for that organization, please contact the respective organization for further information.

So now to get started. Why are we moving to ICD-10-CM? Well, coded data are used much more widely now than when the U.S. transitioned to ICD-9-CM 30 years ago. There are many users of the coded data contained in multiple computer databases, and the list on slide six provides you with just some of the uses for which coded data are being used for today. So in order to make best use for these purposes, we really need to move forward with a more up-to-date and modern coding system. There are also other changes within healthcare that changes our opportunities when using ICD-10. For example, emerging health care technologies, new and advanced technologies, and the need for interoperability amid the increase in electronic health records requires a standard code set that's expandable and sufficiently detailed to accurately capture current and future health care information.

Moving to slide 7, first of all, what is ICD-10-CM? Well, it's a diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care

settings and is intended to replace the ICD-9-CM diagnosis coding system. It is a U.S. clinical modification of the international classification system, ICD-10. This slide gives you some bullet points for a reference on the comparison between the structure of ICD-9 and ICD-10-CM. An ICD-9 code has three to five characters or digits in comparison to three to seven characters in ICD-10-CM. The first character of an ICD-10-CM code is always an alpha character. And all letters of the alphabet are used except for U, while in ICD-9-CM the first character is numerical except for the V and E codes. The letters I and O are used in ICD-10-CM, but they shouldn't be confused with the numbers 1 and 0 because the letters I and O are only used in the first character position. And this character is always a letter. In ICD-9-CM characters two through five are numeric. In ICD-10-CM, character two is numeric and characters three through seven can be either alpha or numeric. In both coding systems, all codes are always at least three characters long, and both systems use a decimal after the first three characters of the code. Also, another feature of ICD-10-CM that's a little bit different is a dummy placeholder of "X" that's used in certain characters of some codes. And I'll explain about the use of this placeholder a little bit later. The alpha characters in ICD-10-CM are not case sensitive, meaning that a lower-case or upper-case version of the same letter has the same meaning.

On slide 8, this gives a depiction of the current structure that we're familiar with in the ICD-9-CM codes, showing that a code like 496 might only be three characters long. 414.00 is an example of a five digit code, and then V55.3 is an example of a code using an alpha character in ICD-9. Again, codes longer than three characters always have a decimal point after the first character. The first character can be alpha or numeric, but only alpha codes are used for the V and E codes, not in the other chapters of ICD-9. And the second through fifth characters are always numeric.

In contrast, in ICD-10-CM, it does have the same hierarchical structure as ICD-9. And all codes with the same first three characters have common traits, with each character beyond the first three adding more specificity. But in ICD-10-CM there can be up to seven characters. Just like in ICD-9-CM, some codes may only be three characters long. For example, P09, which is the code for abnormal findings on neonatal screening, is a complete code. Just like in ICD-9-CM a decimal appears after the third character. Some codes in certain chapters of ICD-10-CM have a seventh character, sometimes referred to as a seventh character extension. It's used in the

obstetrics, musculoskeletal injuries, and external causes of injuries chapters. A code that has an applicable seventh character, even though it's sometimes called an extension, is considered invalid without the seventh character. And the seventh character value must always appear in the seventh character position. Occasionally, a code that requires a seventh character is less than six characters long. In that case, a placeholder of "X" is used to fill in the empty characters so that the seventh character value can appear in the seventh character position. For example, code S77.11, crushing injury of right thigh, requires a seventh character to indicate whether it's the initial encounter, subsequent encounter, or sequela. Since this code is only five characters long and "X" must be placed in the sixth character position in order to appropriately put the seventh character in the seventh character position. So the complete code assignment would be S77.11X followed by the seventh character indicating initial, subsequent encounter, or sequela for the complete code assignment. The seventh character has a different meaning depending on the section but often provides information such as the characteristic of the encounter. For example, in the injury and external cause sections, the seventh character classifies an initial encounter, subsequent encounter, or sequela or late effect. Certain codes, such as fractures, have even more specificity provided by the extension. In the OB chapter, the seventh character is used to identify the fetus affected by the OB condition described by the code when it is a multiple gestation. And – I'll talk –I'll have an example of that a little bit later.

On slide 10, more similarities between ICD-9 and ICD-10-CM are in the structure and format. When you take a look at it, it looks very similar to ICD-9-CM. The chapters are structured very similarly with some minor exceptions. A few chapters have been restructured. And the sense organs, meaning the eye and the ear, have been separated from the nervous system chapter in ICD-10-CM and moved to their own chapters. The index is structured the same as ICD-9-CM where you have an Alphabetic Index of Diseases and Injuries, Alphabetic Index of External Causes, a Table of Neoplasms, and a Table of Drugs and Chemicals.

Just like in ICD-9-CM, ICD-10-CM is divided into an Alphabetic Index and a Tabular List. The index is an alphabetical list of the terms and their corresponding codes. It lists the main terms in alphabetical order with indented subterms under the main terms, just like in ICD-9-CM. And,

again, the index is divided into two parts – the Index to Diseases and Injuries and the Index to External Causes.

In ICD-10-CM, the Tabular List is a chronological list of codes divided into chapters based on body system or condition. The Tabular List is presented in code number order. Since all ICD-10-CM codes start with a letter, all code categories are in alphabetical order according to the first characters. So, for example, chapter one contains code categories A00 to B99. And chapter two contains code categories C00 to D49. And chapter three contains code categories D50 to D89 and so forth. Then within each chapter or section beginning with the same letter, the code numbers are listed numerically. And just as in ICD-9-CM, codes are invalid if they are missing an applicable character. You look a code up the same way in both ICD-9 and ICD-10. First, look up the diagnostic term in the Alphabetic Index and then verify the code number in the Tabular List. One nice feature in the ICD-10-CM codes is that full code titles are provided for the code descriptor. As many of you know in ICD-9-CM, you frequently have to refer back to the beginning of a code category or even back to an earlier section to identify the applicable fourth or fifth digit for a code. And sometimes in ICD-9-CM, a code title only contains some of the words for the code description, and you have to look at the title of the category the code is under in order to know the complete meaning of the code. By contrast, ICD-10-CM provides the complete code titles for each code. The only exception for that is for those codes that require a seventh character, you do have to refer back to the beginning of that category to identify the appropriate seventh character value. But for all of the other codes that don't involve the seventh character and for the descriptor of the code for all pieces of information except that seventh character, the complete code title is provided next to each code number.

On slide 13, many conventions have the same meaning in ICD-10-CM that they had in ICD-9-CM. Many of the abbreviations, punctuation, symbols, familiar notes (such as code first and use additional code note) are used. Nonspecific codes, meaning the codes with words such as "unspecified" or "not otherwise specified' in the code titles, are available to use when detailed documentation to support a more specific code is not available.

The ICD-10-CM Official Guidelines for Coding and Reporting accompany and complement the ICD-10-CM conventions and instructions, just as we have ICD-9 official coding guidelines today. And the ICD-10-CM official guidelines are currently available along with the code set on the CDC and CMS websites. Adherence to the official coding guidelines in all health care settings is required under HIPAA, just as it is with ICD-9-CM. All of the codes, as I mentioned, in ICD-10-CM are alphanumeric. So this is one of the differences from ICD-9. The first character is always alpha. The codes can be up to seven characters in length. Many of the code titles are much more specific than the ICD-9 code titles. And you'll see some examples of that a little bit later. And, again, the code titles are much more complete, where there is no need to refer back to a category or subcategory level to determine the complete meaning of a code. Laterality, meaning the side of the body that's affected, has been added to appropriate chapters including the eye and adnexa, the ear and mastoid process, the neoplasm, and injury chapters. This feature allows you to appropriately classify the right or left side or bilateral. This information is often currently readily available in the medical record but because ICD-9-CM does not capture this information, this data are not being collected. And if the affected side of the body is not documented, there are codes for unspecified side.

One of the great new features of ICD-10-CM is the creation of combination codes for conditions and common associated symptoms or manifestations. This allows one code to be assigned rather than multiple codes and provides a clear linkage between the underlying condition and the associated symptom or manifestation. Another – poisonings and associated external causes – are another example of the use of combination codes with ICD-10-CM. One change in the structure in ICD-10-CM is that injuries are grouped by anatomical site rather than by categories of injury. So all injuries of a site, like head and neck for example, are grouped together rather than grouping together injuries according to type such as all fractures together or all open wounds together. And, of course, one of the major benefits of ICD-10-CM is that the codes reflect modern medicine and updated medical terminology. On slide 17 are some examples of combination codes, and it also shows some of the increased detail that we get out of the ICD-10-CM codes. So I25.110 is atherosclerotic heart disease of native coronary artery with unstable angina. E11.311 is type II diabetes with unspecified diabetic retinopathy with macular edema. K71.51 is toxic liver disease with chronic active hepatitis with ascites. K50.012 is Crohn's

disease the small intestine with intestinal obstruction. And N41.01 is acute prostatitis with hematuria.

On slide 18, this shows you the differences in how injuries are structured within ICD-9 versus ICD-10. So in ICD-9, you have injuries grouped together by the type of injury. So all fractures are in one section, dislocations in another section, and sprains and strains in another section. In ICD-10, they've been reorganized. So it's all the injuries to the head, all the injuries to the neck, all the injuries to the thorax, and so forth. And within those sections are the different codes for the types of injuries that can occur at that anatomical site.

And I had mentioned earlier that a seventh character is one of the additional features in ICD-10-CM. It's used in certain chapters to provide additional information, most typically about the characteristic of the encounter. As I mentioned, it must always be in the seventh character position. And if a code has an applicable seventh character, the code must be reported with the appropriate seventh character value in order to be valid.

For injuries, the seventh character typically identifies whether this is the initial encounter for the injury, a subsequent encounter, or sequelae – meaning late effect. For fractures, in addition to identifying the initial or subsequent encounter, the seventh character also provides information about routine versus delayed healing, malunion versus nonunion, and certain types of open fractures. And the OB chapter – the seventh character, again, identifies the fetus for which the code applies in cases of multiple gestations. For example, the seventh character would be used with codes for fetal anomalies or malposition of the fetus to identify which fetus the codes for these conditions apply to when there are multiple fetuses. Here's an example of the seventh character for the injuries and external causes, with A indicating the initial encounter, D indicating subsequent, and S for sequelae. Note that one big change in ICD-10-CM is – excuse me – instead of using aftercare codes like we're used to today for follow-up care for injuries, aftercare of an injury in ICD-10-CM is captured by assigning the acute injury code with the seventh character D, indicating that it is a subsequent encounter.

On slide 21, some of examples of some of the additional types of seventh character values that are used for fractures where closed versus open fracture is captured, routine versus delayed healing, and nonunion versus malunion.

I had mentioned earlier that ICD-10-CM uses a dummy placeholder "X" in some codes. So now I'll talk about the places in which this placeholder is used. It's used in certain codes as a fifth character placeholder where it will appear – in the – in the code itself, in the classification, in order to allow for future expansion in that area. So, for example, codes involving drugs are an area where this placeholder is used because there can be such an explosion and expansion in the types and categories of drugs. It's also used to fill in empty characters when a code that is less than six characters in length requires a seventh character. And I had provided an example of that earlier where if the code is shorter than six characters and it must have a seventh character, you need to use the placeholder "X" to fill out the empty characters. When the placeholder character applies, it must be used in order for the code to be valid.

In ICD-9-CM, Excludes notes can have multiple meanings. Now I'm on slide 23. An Excludes note in ICD-9 can mean either that the code identified in the Excludes note should never be assigned with the code where the note appears, or it can mean that the code identified in the Excludes note is not included in the code where the note appears, and it would be appropriate to assign both codes when both conditions are present

This can be confusing to a lot of coders because sometimes it may be readily apparent which kind of Excludes note it is, and sometimes it's not so apparent. For example, when an Excludes note for an acquired condition appears under the code for the congenital form of this condition, it's pretty clear that you shouldn't assign both the congenital and acquired codes since they're mutually exclusive. And the patient can only have either the congenital or acquired form of a condition, not both. That's pretty clear. But there are many other instances of Excludes notes in ICD-9 where it is not that clear whether the codes can be used together or not. And that's created a lot of difficulty and a lot of coding questions. However, ICD-10-CM clears this confusion up by providing two different types of Excludes notes – Excludes1 and Excludes2. An Excludes1 note indicates that the code identified in the note and the code where the note appears cannot be

reported together because the two conditions cannot occur together. And here is an example on slide 23 of diabetes, where there is an Excludes1 note indicating that it excludes diabetes due to underlying condition, or drug or chemical induced diabetes, or gestational diabetes. So in other words, the patient wouldn't have type 1diabetes and diabetes due to an underlying condition. It has to be one or the other. So this makes it very clear that these codes cannot be reported together. You cannot assign an E10 code for type 1 diabetes with an E08 code for diabetes due to an underlying condition.

On slide 24, an additional example of the acquired and congenital situation is M21, other acquired deformities of limbs, which has an Excludes1 for acquired absence of limb and congenital absence of limb – meaning that, if that's really what you're looking for and what you mean by the code, then you need to use this other code and not the M21 code. You shouldn't be using the M21 with either one of these codes identified in the Excludes1 note.

On slide 25, an Excludes2 note, on the other hand, 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 those conditions. For example, L89 pressure ulcer, has an Excludes2 note for diabetic ulcers, and nonpressure chronic ulcer of skin, and skin infections, and varicose ulcers. A patient could conceivably have other types of ulcers in addition to a pressure ulcer. So if they do, it's okay to assign the other codes for the other kinds of ulcers in addition to the L89 code for the pressure ulcer.

On slide 26, an additional example of an excludes2 note is I70.2, atherosclerosis of native arteries of the extremities, where there's an Excludes2 note for atherosclerosis of bypass graft of extremities. It's possible to have atherosclerosis in both the native artery and a bypass graft. So if the patient has both, the I70.2 code and the code for the bypass graft atherosclerosis may be used together.

On slide 27, I've provided some examples of the increased specificity in some of the ICD-10-CM codes. For example, S72.044G, nondisplaced fracture at the base of the neck of the right femur, subsequent encounter for closed fracture with delayed healing. You can see how much

more information is in that code that you know about the patient that you don't get from many of the current ICD-9-CM diagnosis codes. I69.351, sequelae of cerebral infarction with hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Again, you can see how much additional information is in that code description. Z47.81, encounter for orthopedic aftercare following surgical amputation. And Z48.21, encounter for aftercare following heart transplant.

On slide 28, I've provided some examples of where laterality is used to show which side a malignant neoplasm of the breast appears on. And you can see the additional information that having that laterality information provides.

Now on slide 29, we're going to walk through a few coding examples just so you can see the process of how to code an ICD-10-CM. And understand that while some of the codes are different or all the codes are different and how they might look different, and be longer, and have some different aspects to them – the general coding process is very much the same. So here on slide 29, we're going to walk through the process of coding hypertension. First, you look up the term in the Alphabetic Index, and unfortunately in this format I can't show you what the entire code book would look like, but they're listed alphabetically by named diagnostic term just as the Alphabetic Index is organized in ICD-9-CM. So you just picture that you're looking at a page of a code book with "H's" on it, and you're scrolling down, and you find hypertension. And you'll see that it has, you know, some nonessential modifiers in parentheses after the term, just like we're used to today, and then gives the code I10. So then the next step in the process is to verify the code in the tabular. So you go to I10 in the tabular. Again, the code numbers are listed in the Tabular List in chronological order, starting with the letter that appears in the first character position. So to find I10, you would go to the code starting with the letter "I" and then find I10 in numerical order after I09.9 and before I11. And you'll confirm that I10 – is the – is the code for hypertension. And there you will see some inclusion terms and some excludes notes, just like you would be used to seeing in codes in ICD-9-CM.

On the next slide, slide 31, here's another example, again, of looking the term type diabetes up when you're trying to code Type I diabetes with diabetic nephropathy. Look up diabetes, find the

indented term of Type I, and then a further indented subterm of with nephropathy, which gives you E10.21.

And on the next slide, you verify the code in the tabular by looking up E10.21, which appears under category E10. And then within subcategory E10.2, and you will see the code E10.21, Type 1 diabetes with diabetic nephropathy, listed there along with some inclusion terms underneath it.

On slide 33, we're looking up stage III decubitus ulcer of the coccyx. You would first look up ulcer, and then you would decubitus, and then it would tell you to "see ulcer, pressure, by site." So you will notice the same use of the cross-reference word "see" that we're used to seeing in the ICD-9 Alphabetic Index. You'll go then to ulcer pressure and then you could look under a subterm, an indented term of coccyx, or you could look under the indented term under ulcer, pressure, for stage III, and then coccyx, both of them referring you to L89.

On the next slide, you'll see you go to L89.15 in the Tabular List, and you will note that L89.15 is not a complete code. So this is a good example of why you should never code from the Alphabetic Index and should always verify the codes in the Tabular List. Because you will see that L89.15 is actually a subcategory for pressure ulcer of sacral region that is further broken down into six character codes indicating the stage. So the correct code for the diagnosis we're trying to code, stage III decubitus ulcer of coccyx, is actually L89.153, within that L89.15 subcategory.

On slide 35, if you were going to look up postmenopausal osteoporosis with current pathological fracture, the vertebra, and this is the initial encounter for the fracture, you would start by looking up the main term osteoporosis and postmenopausal. And the line on your slide there that says "with pathological fracture" was inadvertently omitted from your slide. But – so just picture that under postmenopausal, if you had another indented line there, it should say "with pathological fracture." And then underneath that would be a further indented term, of vertebra, referring you to M80.08. If you go to M80 in the tabular and look down to M80.08, you will see the code there for age-related osteoporosis with current pathological fracture of the vertebra. You will see under M80 the appropriate seventh character value for the codes in this category, and so we know it's

the initial encounter. So the seventh character is an "A." However, notice that M80.08 is only five characters long. And remember what I talked about earlier, that a seventh character value must always be in the seventh character position. So you would report M80.08x – the placeholder "x" – and then the "A" in the seventh character position.

On slide 37, for dislocation of the jaw, subsequent encounter. Again, you would look up the main term, dislocation of jaw, which then sends you to S03.0 in the tabular. You would verify the code in the Tabular List and see the code for dislocation of jaw. And, again, this particular code requires a seventh character. And in this case, S03.0 is only four digits long. So it requires a placeholder "x" in both the fifth and the sixth character positions in order to put the "D," for the subsequent encounter, in the seventh character position.

On slide 39, late effect of stroke with facial droop. Again, look up late effect. You'll see an instructional note to see sequelae. And you look up sequelae, there will be an indented term of stroke. And then a further indented term under that of facial droop, sending you to I69.392.

And when you verify that in the Tabular List on slide 40, you will see that I69.392 is the correct code, facial weakness following cerebral infarction, and it includes facial droop according to the inclusion terms.

On slide 41, you're coding aftercare following hip replacement. The hip replacement is not for a fracture because there are different rules for fractures. You would look up aftercare following surgery of the indented term, and then under that joint replacement as a further indented term, which indicates Z47.1.

And then when you verify the code in the Tabular List, you will see Z47.1, aftercare following joint replacement surgery with a use additional code note underneath indicating that you would add a code to indicate what joint is affected. And, again, notice the familiar use of many of the notes we're familiar with in ICD-9 such as this use additional code notes. So that kind of gives you some examples of how you go about the process of looking up codes in the ICD-10 and

verifying the final code assignment. And how many of the steps in the process are very much the same as ICD-9 that you should be familiar with.

On slide 43, I'm just going to talk a couple of minutes about some of the ongoing myths about ICD-10. And these were taken from the ICD-10 fact sheet on myths and facts that's posted on the CMS website. One myth is that there won't be any hardcopy ICD-10-CM code books, and that all coding will need to be performed electronically. Well, that's not true. ICD-10-CM code books are actually already available by some publishers. And I can vouch for the fact that they are a normal, manageable size and not 10 feet thick or anything like that. The use of the ICD-10-CM is not predicated on the use of electronic hardware and software. Of course, just as with ICD-9-CM, there will be encoders and other electronic tools available to facilitate the coding process. But it's not required that people use electronic tools in order to use the ICD-10-CM. On slide 44, another myth is that unnecessarily detailed medical record documentation will be required. Well, as with ICD-9-CM, ICD-10-CM codes should be based on medical record documentation. And while documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when the documentation doesn't support a higher level of specificity. In fact, in a field testing study of ICD-10-CM conducted by the American Hospital Association and AHIMA, much of the details contained in ICD-10-CM is already in the medical record documentation, but it's just not being utilized because it's not needed for the ICD-9-CM codes.

Another myth is that the increased number of codes will make ICD-10-CM impossible to use. Well, just as the size of a dictionary doesn't make a dictionary more difficult to use, a higher number of codes doesn't necessarily increase the complexity of the coding system. In fact, greater specificity makes it easier to find the right code because it's clearer that you're in the right place. Because ICD-10-CM is much more specific and more clinically accurate and uses a more logical structure, it can be much easier to use than ICD-9-CM. And just as it isn't necessary to search the entire list of ICD-9-CM codes for the proper code, it's also not necessary to conduct searches of the entire list of ICD-10 codes to find the right code. As I showed you with the examples earlier, you follow the same process of looking up the terms in the index and then going to the tabular to identify the appropriate code for the condition you're trying to code. The

index and electronic coding tools will continue to facilitate proper coding selections just as they do with ICD-9-CM. And it is anticipated that the improved structure and specificity of ICD-10-CM will facilitate the development of increasingly sophisticated electronic coding tools that will ultimately assist in much faster code selections.

On slide 47, well, what is the impact of ICD-10-CM on coding and documentation? Well, certainly the full benefits of ICD-10-CM will not be realized if we don't take advantage of the increased specificity. More detailed documentation will result in a more accurate clinical picture and better data for supporting the many purposes for which coded data are used today as well as the uses for which coded data will be used in the future. However, improved data are likely to occur even without improvements in documentation simply because the greater detail in ICD-10-CM takes advantage of the clinical information already contained in medical record documentation but that is not currently being captured by the less-specific ICD-9-CM codes. It is anticipated that improvements in ICD-10-CM such as more complete and specific code titles, updated medical terminology, and expanded and clearer instructional notes will facilitate the coding process and make it easier to code accurately and efficiently. Earlier, on one of the myth slides, I referred to a field testing study conducted by AHIMA and the American Hospital Association several years ago. This study concluded the ICD-10-CM codes can be applied to today's medical records in a variety of health care settings without having to change documentation practices although, of course, improved documentation would result in higher coding specificity in some cases. In that study, only 12 percent of the assigned codes in the study were in the nonspecific category, meaning that they had "unspecified" or "not otherwise specified" in the code title even though physicians were not asked for clarification or additional documentation as part of the study, indicating that the medical record documentation necessary to support coding specificity was actually present in the majority of cases. In that study, 6,177 medical records in a variety of health care settings including inpatient hospital, outpatient hospital, post-acute settings, physician practices, and freestanding outpatient facilities were coded using ICD-10-CM. However, it's important to keep in mind that nonspecific codes are still available in ICD-10-CM when the detailed documentation to support a more specific code is unavailable.

Improved medical record documentation is not predicated on the change from ICD-9-CM to ICD-10-CM. However, improved documentation is being driven by a lot of other external initiatives such as quality measurement reporting, value-based purchasing, and patient safety. So provider organizations should anticipate and try to improve documentation capture prior to ICD-10-CM implementation to avoid having to rely too heavily on unspecified codes or hold up claims trying to address documentation deficiencies retrospectively. One way to start working on assessing and improving documentation now is to review the medical record documentation for the most frequently coded conditions in your organization and compare it to the ICD-10-CM codes for these conditions.

So how to get started with training for coding personnel. Well, it's too early to start intensive in-depth ICD-10-CM training for coding professionals. The most effective time for in-depth training of coding professionals to ensure proficiency in assigning ICD-10-CM codes is thought to be six to nine months before the implementation date. Providing the right training at the right time is necessary to ensure that there's sufficient time for learning and to avoid retraining. Training on any particular issue should be deployed close to the effective date for the individual. And acquiring knowledge months or years before it's applied is not efficient, as this inevitably results in varying amounts of follow-up and retraining that consumes additional training resources. Since ICD-10-CM has the same hierarchical structure, the same basic organization, and many of the same conventions as ICD-9-CM, experienced coding professionals will not require the level of extensive training that would be necessary for an entirely new coding system. They will already be familiar with the logical hierarchy and the basic ICD rules. As I showed you earlier, many of the features of ICD-10-CM are very similar to ICD-9-CM. So experienced coding professionals will primarily need to be educated on changes in the structure, disease classification, definitions, and guidelines. So it is anticipated that those coders who are already proficient in ICD-9-CM require only a couple of days of training to make the transition. And I think that's an important point for people to realize – that it's about really two days of training for someone who is already proficient in ICD-9-CM to thoroughly learn ICD-10-CM. And that includes:

About six hours learning the fundamentals of ICD-10-CM to understand the code structure conventions, related coding guidelines, and how ICD-10-CM is different from ICD-9-CM;

Six hours and more intensive training applying ICD-10-CM coding conventions and guidelines; and

Four hours practicing applying the ICD-10-CM codes to typical encounters in their organization to gain proficiency in code assignments.

So on slide 50, what can coders start doing now to prepare since it's too early for the actual intensive, in-depth coding training? Well, certainly, it's time to do exactly what you're all doing today and that's start learning about the structure, organization, and unique features of ICD-10-CM. And start using assessment tools to identify areas of strength and weakness in the biomedical sciences including anatomy, physiology, pathophysiology, pharmacology, and medical terminology. And the results of these assessments can be used to determine who might benefit in a review or a refresher course in biomedical sciences and what aspects of the biomedical sciences this review should be focused on. Assessing individual competence allows the organization to focus on prioritized training resources, and provide training where it is most needed, and tailor the training plan to the individual. Measuring the coder's baseline knowledge now and providing refresher education where needed will help to focus limited educational resources and ensure adequate staff preparation and will ultimately shorten the learning curve, improve coding accuracy and productivity, and accelerate the realization of the benefits of ICD-10-CM.

So that concludes my presentation on ICD-10-CM. On slide 51, I've provided the website for AHIMA's ICD-10 resources. There are a variety of articles and other resources that are freely available including a practice guidance on the GEMs, the General Equivalence Maps, between ICD-9-CM and ICD-10-CM; a preparation checklist that's freely available; and there are also some role-based implementation models on our website as well. A Pocket Guide of ICD-10-CM and ICD-10-PCS is a very handy, quick reference guide available at a very nominal fee that provides a lot of quick, easy information about ICD-10 – at your fingerprints – at your fingertips without having to search through large documents. It gives you the information about the digits, the features, some of the unique characteristics, and the various chapters, implementation

strategies, and so forth. There are also some online courses we offer. We have a freely-available electronic ICD-10 newsletter, some assessments that we provide on assessing your proficiency related to ICD-10 – some of those assessments I had talked about earlier in implementation planning. And we are providing academies for people who are going to train other people in ICD-10. And we do have two upcoming academies aimed at people who wish to train in ICD-10-CM only and not ICD-10-PCS, and those dates are listed here on this resource slide. And more information can be found on our website. And now I'll turn the presentation over to Pat to talk about some additional resources.

Pat Brooks: Thank you, Sue. That was very informative. Looking at slide 52, you will see that we do have ICD-10 information on our CMS website. For those of you who want even more about ICD-10 and perhaps are interested in doing a conversion project from ICD-9 to ICD-10, we do have a report on an MS-DRG conversion project that CMS undertook where we took our payment system for inpatient hospitals that's ICD-9 based and converted it to ICD-10. And in that report – I believe it's 119 pages long – we share lessons learned and make recommendations to others who are interested in undertaking a similar type of a task. The second bullet on slide 52 shows that we do have general ICD-10 information, and you should check that website periodically to look for updates.

Slide 53 shows that sometimes people, when we have these outreach calls, ask for information about what products that vendors have available. Well, two organizations have volunteered to provide information for providers on ICD-10 resources. We don't necessarily from CMS endorse any product over another, but we're pleased that groups such as WEDI and HIMSS – and you see the two websites – are making websites available for vendors to report products that they have. And that may be a good tool for you to look through. And I'll turn it back over to Ann now.