

Centers for Medicare & Medicaid Services
ICD-10 Implementation Strategies for Physicians National Provider Call
Moderator: Leah Nguyen
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Part 3 of 4 Audio Recordings

Question and Answer Session

Leah Nguyen: Welcome to the third of four podcasts from the National Provider Call on ICD-10 Implementation Strategies for Physicians. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, August 3, 2011.

In this third podcast, CMS subject matter experts respond to questions about ICD-10 implementation.

Question and Answer Session

Marcella Jones: OK, we're from Health Partners Home Health Care, and we just tried to go to the proposed rule text, the site for that that's given, and it's says content unavailable. Is this not the correct address or is it not available?

Leah Nguyen: It must be not available, because I happened to check it earlier and it was working fine.

Joan Proctor: Yes. There are times in which there are things going on that you will find sometimes you'll get that. However, two hours ago I was able to go on and access it. So, any additional information I'll be glad to follow up with you.

Elizabeth Zappa: Hi. This is Liz from 1199 Benefits Fund, and I believe during your May teleconference you talked about doing a readiness survey and expanding it to

120 providers and health plans, and I was wondering if that was completed and when the outcome results would be available to the public.

Leah Nguyen: Hold on one moment.

Leah Nguyen: Hello. This is Leah Nguyen. We don't have the correct date in front of us, If you could go ahead and submit your question to our resource box that's listed on – I believe it's slide 80- and just go ahead and put that in the subject field, then we can get back to you.

Louise Cheher: Thank you very much. Good afternoon.

Just a quick question on slide 65, where's it's dealing with the transition for Medicaid. How do we find out if our state is one of the high risk or moderate risk?

Kyle Miller: If you submit that also to the box, I could provide you with the link that you can go to where there's an interactive map.

Louise Cheher: OK.

Kyle Miller: And you can look at your respective state.

Louise Cheher: That would be great. Thank you.

Kyle Miller: No problem.

Operator: Your next question comes from the line of Madden Brassard. Your line is open.

Madden Brassard: Yes. The question is how much the economical impact will be on solo practitioners? I mean, after converting the ICD-10.

Dr. Daniel Duvall: Right. The economic impact again depends on exactly how your office is set up. In terms of payment, it doesn't make any difference to payments for solo practitioners or for practitioners at all. From the standpoint of office investment, it depends on really how much IT involvement your office has. If you're talking about from the bottom end of the solo practitioner where you

actually submit paper claims, it involves getting a new coding book and getting some new paper claim forms.

As you go up from there, for most claim submission systems, it's going to depend on the individual supplier that you've got as to how they're pricing their systems from year to year. They do have a development cost in terms of updating their system, but, again, these are systems that are generally being continuously updated anyway.

The significant financial impact comes in those practitioners that have made a significant IT investment into some type of a customized system and even there it depends on exactly how the system was customized. So, for most solo practitioners, it should be small but it's not a guarantee. You have to look at exactly what your IT footprint is.

Madden Brassard: If you are using electronic billing?

Dr. Daniel Duvall: Right. Again, using electronic billing, there are certain types of free software for electronic billing- that's going to have no financial impact on you. If you're using something that you're purchasing from someone, you might see an increase in their rates from one year to the next or you may not. It all depends on how they fit their development cost into their year-to-year pricing schemes.

So, again, it should not be large. If it is, you need to talk to your supplier and talk to his competitors.

Loretta Shepherd: You say that it's not going to be much expense for the office other than just getting the code or looking the codes up. Our concern is the requirement now from insurance companies to prove these new codes and the cost of transmittal of additional information. Has that even been looked at with this?

And, also, with the way that our Medicare costs are skyrocketing, is the amount that our government and their encephalitis headache having to pay for this system worth the amount of money it's costing the American public?

Dr. Daniel Duvall: Let me answer those questions in reverse order. This is Dan Duvall.

In terms of the benefit for the cost of this encephalitis headache, absolutely. This is me speaking both, I think, officially as CMS but also personally, just in terms of my own evaluation, both from what I've seen at CMS and from my experience in the industry before coming to work for the government. The ability to do the more sophisticated data processing and data analysis is critical, and the expected pay offs both at the government level and at individual institutional levels is pretty significant.

Moving on to the second part of your question, or the first part of your question, about proving the codes- I'm not sure exactly how you mean that the insurance companies are wanting you to prove the codes. The coding requirements under ICD-10 are no different than they are under ICD-9. The code that you use reflects the actual clinical circumstances of the claim.

Now, from the standpoint – one of the worries of the insurance companies is making sure that their aggregate payments aren't going to change when the system moves from 9 to 10. That's their worry, not the individual provider worry. So, that's not something that they should be passing on or that they really even can pass on to provider offices.

Loretta Shepherd: Well, it's been our – what we've had to deal with is that any time there's a code change, they require us then to produce all the records so that they can look at all the records to show that we're using the proper code and to prove that the code that we're using is the appropriate code for that particular patient.

And we've been on EMR now for almost 2 ½ years, and every time we have a code change we have an overwhelming need to send additional records to prove to the insurance companies that what we're listing in our claims is accurate. And it takes so much time for our employees, you know, having to do that on an ongoing basis. And time for the doctors to have to review those records before they go out.

Dr. Daniel Duvall: Got it. I understand what you're talking about. That's not the same issue that we're going to have with moving from ICD-9 to ICD-10.

Now, the individual commercial insurers- and actually Medicare Fiscal Intermediaries or the MACs and anyone that's receiving claims- are going to have questions about whether claims are correctly coded, but we're actually now talking about every single claim that comes into them. So, it's not an issue of focusing on particular providers and looking at either recoding of individual claims or of using new codes correctly when a couple of new codes come out.

Because this is global, you can't have an across-the-board approach of saying I'm going to need to look at everything. It is unachievable from an insurance company standpoint. So, that would be a worry that I would push aside. In some sense, moving from 9 to 10 is putting everybody back at the starting gate, Everyone's starting evenly, so you may even find this to be an advantage.

Bill Singletery: Thank you. I have a question for Dr. Duvall. I enjoyed your presentation very much, but one of the messages I was hoping to hear as you were discussing the impact on physicians in achieving appropriate payment and proper stratification of morbidity was the importance of higher specificity in physician documentation. And I think ultimately that is what's going to drive accuracy in coding and provide the audit defensibility and appropriate payment that is needed.

Could you please speak to that?

Dr. Daniel Duvall: Sure. This is Dan Duvall. I agree 100 percent and although it's not quite related to ICD-10, it makes a great Medlearn topic, and in fact actually is a Medlearn topic that I was writing on a little bit earlier today.

So, this is an ongoing issue, and it is equally important under 10, if not more important under 10. Coders cannot code what's not in the claim- what's not in the medical record. Sorry. And as you find that there are more gradations of codes, more opportunities for coders to pick from a list, they're going to be coming back to physicians early on a little bit more at the beginning to say, wait, I need more definition to help me pick A or B.

Now, ICD-10 has some less specific options, but as you use the less specific options, you lose the ability to do that sophisticated data analysis, the sophisticated stratification. So, the message that I would expand on, starting from your message, is not only is it important for physicians to be more specific in their codes – in their medical record documentation, but this is an opportunity to enlist their coding staff to move away from the comfortable position where they're in of, oh, yes, I know exactly what Dr. Smith is thinking, so I can write it down even though his medical record just says "looking well," and move to a, "Dr. Smith, can you give me a little bit more information, document it to help me select my code?"

And that's going to give you a medical record that is going to stand up a lot better to audit and hopefully be better from a patient care standpoint. Because remember what we're really looking for in this information is not the payment. The payment's important, but what we're looking at is this electronic health record idea where what you write down is going to be shared with a lot of other doctors.

Speaking as an E.R. doctor, when I have access to an electronic medical record and pull up somebody's office notes, if all it says is unchanged, I haven't learned anything. But if your coder's pushing you for that more specific information to help their coding, that's going to give me more information and hopefully have better patient care come out as well.

So, great point.

Jackie Kravitz: Thank you. I actually have two questions, as I was listening to everybody else's I thought of one. I apologize. But the first one is with two years to go and with the high learning curve that we have, when do you suggest sending coders to start their CEUs, to understand exactly how ICD-10 works?

And also, my second question is how does the government plan to pay for this ICD-10 coding debacle, because 30 percent of our cost reduction that was just voted on by our government is coming from Medicare?

Mady Hue: This is Mady Hue. I'll answer your first question regarding coder training.

In previous calls and today, I would still recommend that you seek training no more than six to nine months prior to the implementation date for ICD-10.

Jackie Kravitz: No more than six to nine months?

Mady Hue: Correct, because...

Jackie Kravitz: OK.

Mady Hue: ... as I discussed, we're in partial code freeze and over the next couple of years there is the possibility that we could have new technology or new diseases, new procedure codes and new diagnosis codes. So, the current code set that's out there are still consider draft form.

Jackie Kravitz: Thank you.

Mady Hue: You're welcome.

For the second question, I would recommend submitting that to the providers' box on slide 80 that was linked.

Jackie Kravitz: Yes. Well, thank you very much.

Mady Hue: You're welcome.

Operator: Your next question comes from the line of Natasha Cooks. Your line is open.

Natasha Cooks: Yes. With regard to the laboratory NCDs, is it seen as an intention to provide the ICD-9/ICD-10 conversion with enough time for the industry to comply with it? And the follow up to that will be, will CMS impose a similar timeline for the MACs to publish the LCD counterpart?

Lisa Eggleston: Hi. This is Lisa Eggleston. As I had said in my comments, because it came up quite often on the May 18th call, I wish I could say we're going to post it on blank, blank, blank date, but I can't right now. But as soon as we can, we'll make sure that that information is available on the I-10 website. But, you

know, our goal would be to make sure that industry has enough time for their purposes as well.

Marcie Case: Hi. One of the comments was that we should bring in ICD-10 now, and I'm just wondering how you can do that when it's two years away?

Mady Hue: Hi. This is Mady Hue. Could you elaborate a little bit about what you mean by bring in ICD-10?

Marcie Case: Well, we were on page 40 and Dr. Duvall said it would be a good idea to bring in ICD-10 now. We were talking about improving third – the pros were improving third party payments, improving quality in performance, and he said it would be a good idea to bring it in now, and my question was how can we bring it in now?

Dr. Daniel Duvall: This is Dan Duvall. I can answer that one.

Actually, it would be great if we could bring it in now from a data standpoint. I would love to have the data that I could find in the 10 codes at my fingertips when I'm trying to analyze things.

What I was actually talking about was bring it in now as in the timeline that we're currently on, because there are some people out there that's still talking about, well, can't we postpone this until, you know, 2020, 2050, God knows when? And the – my point really is, no, we're well down the pathway with a cut over point in 2013, and my recommendation is let's keep on that pathway and – I mean, and certainly CMS is going that pathway- but everyone else, should emotionally be on that pathway with the idea of, yes, we want it as soon as we can, and that's going to be October 2013.

Marcie Case: So, it's not physically bringing it in now but emotionally we should be starting to do some kind of conversion and stuff like that?

Dr. Daniel Duvall: Exactly.

Marcie Case: ...conversion on paper, but not bring it actually to our computers or anything like that.

Dr. Daniel Duvall: Right. You should be talking with your suppliers, talking with your computer people, making sure that you're thinking about it. And the closer that we get to 2013, the more you should be thinking.

You don't want to wait until 2013 and think about it for the first time then.
But...

Marcie Case: Oh, no. .

Dr. Daniel Duvall: ... you're not bringing it in today.

Marcie Case: OK. OK, I just – I misunderstood that. OK, thank you.

Leah Nguyen: Thank you for listening to this ICD-10 national provider education podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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