

Dr. Daniel Duvall: This is Dan Duvall.

The answer is not to continue to document the way that you've always done it in the sense that if your documentation has always been inadequate, then don't keep doing that. But for physicians whose documentation has been detailed, which is what you should expect from physician documentation, then what they need to continue to do is to document adequately, and the coding derived from the documentation.

So, are there some things that they – that the coders will have to go back and do different, you know, interact with the physicians? Yes. That was what we were talking about. It's an opportunity to improve the documentation.

Is that true? It depends on the offices. I've looked at a lot of different office medical records, and there are a lot of them where you have physicians that are used to documenting extensively and they won't need to do anything differently. The ones that sort of like ones that I was talking about where all you saw was a blank piece of paper that said patient's doing well? Well, they have to do something different, but that's not really because of ICD-10. They need to be doing that differently anyway.

Susan Wertz: I agree that they need to be doing it differently anyway, but ICD-9 allows them to go with less specificity than ICD-10 will, and you've got a lot of physicians out there that really don't believe that this is going to impact them very much. Therefore, their documentation is just what they need to get by.

When we look at what the payers – looking at the payer policies that are going to go into place with the specifications- of a specificity – excuse me – that's coming into play with ICD-10, how do we – you know, your point is saying to the doctor, this is, you know, just a tension headache, but I see this more as a migraine – very much a migraine with physicians that are just coding, just documenting enough to just get by and how that's going to impact their coders.

You know, you talk about, you know, diabetes codes, and looking at that. Well, there's 250 choices in ICD-10 for diabetic codes alone.

Sherrie Burkham: OK, what is it that I go to? I'm sorry.

Mady Hue: There's the link on the resources page, but I can go ahead and just give you the website.

Sherrie Burkham: OK. Thank you.

Mady Hue: [www.cms.gov/ICD10](http://www.cms.gov/ICD10). And there you would look for the ICD-10-PCS and GEMs files, and then also the ICD-10-CM and GEMs files. And there you'll find the code descriptions, the code titles. You'll find the tables and the index, the reference manual slides, so there's lots of resources out there.

Sherrie Burkham: Oh, good. Thank you so much.

Mady Hue: You're welcome.

Sherrie Burkham: Yes.

Operator: Your next question comes from the line of Susan Wertz. Your line is open.

Susan Wertz: Hi. Thanks for taking my call.

A question regarding the documentation or creating of a job aid. Superbills, I don't see superbills being able to be used in the future, as far as ICD-10, only because of the specificity that's going to be required. The – I guess the biggest thing that I'm dealing with is the comment regarding that the physicians or even small practices really aren't going to be impacted by this a whole lot.

When I look at documentation and there's no specificity that's going to be paid by the payers and, you know, with the lack of detail. And I do have a good, solid grasp of ICD-10, and I've actually already started to do my own internal audits. You know, I just – I don't understand where this is coming from with the small positions to – or physicians to just be don't worry about it and continue documenting the way that you're documenting, which has always been an issue from a coder's standpoint to begin with.

Dr. Daniel Duvall: That's true. So, there's considerable variation as you move from specialty to specialty. And, again, going back to that one comment that I made that it was actually the physicians within the specialties that wanted this additional ability to drill down into detail.

Now, there are ways even within ICD-10 of handling records that are not coded- that are not documented fully. So, if you are stuck with one of these physicians who's just about to retire and there's no way you're going to change his documentation because he's been doing it that way for the last 45 years, there's – you can still code that under ICD-10. You lose information, so we don't want to encourage that, but you actually don't have to force him to do something different in order to be able to code the claim under 10. However, you've got the opportunity again to improve it.

And the number of new choices that you have depends on the diseases that the physician is dealing with. If you take diabetes, for example, those – the information that you need to code from those 250 choices is still usually in the medical record, but it's not in the same places that you're used to seeing it, which means that your opportunity for the office – you have two opportunities or two options.

One option is you just say, well, we take the record that comes to us and we go through it and we try to pull out which one of those 250 we pick. If you do that, your rate of coding is going to drop off precipitously. It's going to take you a lot longer to code individual claims.

On the other hand, if your doc is seeing a lot of diabetes and you work with him with getting back to that superbill or the list of common diagnoses concept of, OK, what do you see most often – the most often? What subconditions or what information can you put down that will help me pick which of the five of those 250 that I'm going to be using most often? Because it is going to be a small subset of them. You're not going to be equally distributed across the 250.

That's the opportunity that's going to let you increase the – improve his documentation, not really impacting him. He doesn't have to think about ICD-10 to do this. He just has to think a little bit about where -helping you to find where the information is. But that's also going to help your coding and make sure that you don't have that significant drop off in rate of coding when you switch over.

Susan Wertz: I guess what I'm really looking for is, you know, what I heard I guess coming out and listening to this was saying, you know, physician participation isn't going to have to be very large. So even in such as, you know, the specificity in the MIs with the ST versus non-ST, the non-ST levels, that has to be documented in order to code appropriately in ICD-10, where they don't necessarily need to have it now.

The physician education that needs to go on is a lot bigger than I think people realize as far as that documentation is concerned to make sure that it is documented. And I understand what you're saying. By taking your top 30, I would actually look at a little bit more than 30 codes, but then the practice and especially if you're dealing at a family practice or a general practice, I think they're going to get hit the hardest on this just because of the code selection that's there.

Dr. Daniel Duvall: Yes. I mean, there's – those are good points, and I think it's fair to say that one could look at it that it's going to take you five or 10 years to really train your physicians well to document what you need, except for the fact that if you look at our current crop of physicians, me included, can you really say that you've trained us well? The answer is no. So, it's an ongoing effort.

It's the same battle you're fighting with the existing ICD-9. You're going to continue to be fighting it in ICD-10. But you're right. It's going to require work with the physician.

Susan Wertz: Yes. And then there's going to be a cost to the physician, small or large, if that documentation is not going to be there for the specificity that's going to be required by the payer to get that claim paid.

Centers for Medicare & Medicaid Services  
ICD-10 Implementation Strategies for Physicians National Provider Call  
Moderator: Leah Nguyen  
August 3, 2011  
1:00 p.m. ET

Part 4 of 4 Audio Recordings

Question and Answer Session Continued

Leah Nguyen: Welcome to the fourth 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 fourth podcast, CMS subject matter experts continue to respond to questions about ICD-10 implementation.

**Question and Answer Session continued**

Operator: Your next question comes from the line of Sherrie Burkham. Your line is open.

Sherrie Burkham: Hi. My name is Sherrie Burkham. I'm with Amarillo Colon and Rectal.

We – I have a question about the inpatient codes, because we do inpatient surgeries, and are those codes going to change?

Mady Hue: Yes. This is Mady Hue. In my review, I went over that for inpatient the diagnoses codes for ICD-10 are ICD-10-CM. And for the inpatient procedure codes, those will be ICD-10-PCS.

If you go to the links that were provided on the resources slide, we have the draft complete codes for both diagnoses and procedures on our website. So, I would encourage you to go out there and you can take a look. And ...

Troy Mayer: Hi. Just a couple of quick questions.

One quick question is the updates for the new codes, in what format will they be? And how will we be able to get them?

Mady Hue: OK, this is Mady Hue, and are you talking about the diagnosis codes, procedure codes?

Troy Mayer: Yes. Actually, will they be – let's see – in a PDF? Will we be able to get them at an – let's see – an XML file...?

Mady Hue: If you go out to the website that I listed on the slide and as mentioned earlier, the [cms.gov/ICD10](https://www.cms.gov/ICD10).

Troy Mayer: Right.

Mady Hue: You'll see the files that are currently out there.

Troy Mayer: I see the PDF files, but I was under the impression there might be other formats that you have.

Mady Hue: So, the formats that are out there currently are the ones that are available.

Troy Mayer: OK.

Mady Hue: If you are requesting a specific format, you could submit that to the – that box, the ICD-10 mailbox.

Troy Mayer: OK.

Leah Nguyen: On slide 80.

Mady Hue: On slide 80.

Troy Mayer: OK.

Mady Hue: Otherwise, the ones that I'm aware of are the HTML and text files.

Troy Mayer: OK. Yes, so the text file and HTML. OK.

And just one very quick one is will there – well, actually your last caller talked about the specificity issue, so I’m assuming that there will be a certain specificity that’s necessary for any kind of payments.

Mady Hue: I won’t speak to the payment aspect, but for the codes themselves, as Dr. Duvall indicated, there are codes available for the unspecified conditions if the physician’s documents are less specific.

Troy Mayer: OK.

Dr. Daniel Duvall: This is Dan Duvall. Let me remind you that for most claims other than the inpatient hospital claims and some of the similar types of claims in other environments like home health and things like that, the – it’s not the ICD code that drives the diagnosis. So, for a lot of claims, it’s- you’re looking at other elements of the claim.

Troy Mayer: OK. Thank you very much.

Leah Nguyen: Jessica, it looks like we have time for one final question.

Operator: Your final question comes from the line of Steven Dion. Your line is open.

Steven Dion: Yes. Thank you.

We have a question related to the overall sort of private payer loop of organizations out there, the Aetnas, the Uniteds, et cetera. Do you all have a sense as to what translation mechanism this sector is planning on using for ICD-10? Do you have a sense as to whether the GEMs file is what they’re using as a rule or any – if there’s any knowledge on this topic at all?

Leah Nguyen: Hold on for one second.

Dr. Daniel Duvall: This is Dan Duvall. The GEMs is available, and it’s the starting point that by and large most areas of the industry are using. That doesn’t mean that they’re adopting it exactly as it is, and because even the GEMs as written gives you a

framework but doesn't help you on a case-by-case basis. So, you can look at it as variations of the GEMs, but even if you started from scratch you would still end up with something that looks pretty similar to the GEMs.

Leah Nguyen: Unfortunately, that is all the time we have for questions today.

Before we end this call, for the benefit of those who may have joined the call late, please note that continuing education credits may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS National Provider Calls. Please see slides 77 and 78 of the slide presentation for more details.

Also, if you are interested in being notified when ICD-10 announcements are made by CMS or when new material is posted to the ICD-10 website, you can register for two e-mail notification services: CMS ICD-10 Industry E-mail Updates and the ICD-10 Latest News Page Watch. Links to these resources and registration instructions are located on slide 79.

We would like to thank everyone for participating in this CMS ICD-10 Implementation Strategies for Physicians National Provider Call. An audio recording and written transcript of today's call will be posted to the CMS Sponsored ICD-10 Teleconferences section of the CMS ICD-10 web page at [www.cms.gov/ICD10](http://www.cms.gov/ICD10).

I would like to thank our speakers Mady Hue, Dr. Daniel Duvall, Lisa Eggleston, Kyle Miller, Sarah Shirey-Losso, and Joan Proctor for their participation. Have a great day everyone.

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.



This document has been edited for spelling and gramatical errors.

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