Centers for Medicare & Medicaid Services
ICD-10 Implementation in a 5010 Environment
Moderator: Hazeline Roulac
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12:00 p.m. ET

Welcome

Operator: Good afternoon, welcome to the ICD-10 Implementation in a 5010 Environment conference call. All lines will remain in a listen-only mode until the question and answer session. Today's conference is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line.

Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Thank you for participating in today's call. I will now turn the conference over to Ms. Hazeline Roulac.

Ma'am, you may begin.

Hazeline Roulac: Thank you Christopher. Hello and welcome to the CMS Provider Communications Group National Provider Conference Call: ICD-10 Implementation in a 5010 Environment. I am Hazeline Roulac and I will be your moderator.

We are very glad to have you with us today. There was a tremendous amount of interest in this call and we apologize that we were not able to accommodate everyone who tried to register.

This conference call is being recorded and transcribed. So for those who were not able to join us today, written and audio transcripts will be posted to the CMS ICD-10 website at www.cms.gov/icd10.

You will be able to look for these transcripts in the next few weeks in the Downloads section of the CMS Sponsored Calls area of the site. A slide presentation has been prepared for today's call and is posted on the CMS website at www.cms.gov/icd10 in the Downloads section of the CMS Sponsored Calls area of this site.

If you have not already done so, we encourage you to print the slide presentation so that you may follow along with our speakers. Following the presentation, you will be given an opportunity to answer – to ask questions of our speakers.

If you have your slide presentation available, I would like you to turn your attention to the continuing education information on slides 50 and 51 of the presentation. If you do not have the presentation with you, I will read the information that's on the slide.

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 Conference Call. The AAPC – excuse me – this is the AAPC's language that they have provided to us.

~~–~~If you have attended or are planning to attend one of CMS' National Provider Conference Calls, you should be aware that CMS does not provide certificates of attendance for these calls. Instead, the AAPC will accept your e-mailed confirmation and call description as proof of participation.

Please retain a copy of your e-mailed confirmations for these calls, as the AAPC will request them from any conference call you enter into your CEU Tracker if you are chosen for CEU verification. Members are awarded one CEU per hour of participation."

Slide 51 for the AHIMA. –AHIMA credential holders may claim one CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA nor does the CEU certificate need to be provided in order to claim AHIMA CEU credits.

For detailed information about AHIMA CEU requirements, see the Recertification Guide on AHIMA's website."

The statements that I've just read are standard language provided to CMS by the AAPC and the AHIMA. If you have any questions concerning either statement, please contact the respective organizations and not CMS.

And one final announcement before I turn the call over to our speakers, please mark your calendars for Monday, September the 13th, 2010 from 12 noon to 1:30, Eastern Time, for follow-up discussion of today's topic. Agenda topics will be announced later this summer. We anticipate enormous interest so we encourage you to register early when the call is announced.

OK. We are pleased to have with us today two CMS subject matter experts on ICD-10 and 5010.

We would like to welcome Pat Brooks, Senior Technical Advisor in the Center for Medicare Hospital and Ambulatory Policy Group, and Christine Stahlecker, Director of the Division of Medicare Billing Procedures in the Office of Information Services.

Pat and Christine will review basic information related to ICD-10 and 5010 and how they are interrelated. Discussion topics include ICD-10 implementation issues, proposals to partially freeze code updates, implementation of 5010 updates including when 5010 will be implemented, who will be impacted, and advice, and resources to help you move toward ICD-10 and 5010 implementation.

It is my pleasure to now turn the call over to our first speaker, Pat Brooks.

Pat Brooks: Thank you Hazeline.

Hazeline Roulac: Hi, operator, we have feedback or an echo. Can you hear that?

Operator: Yes. We have just corrected the problem.

Hazeline Roulac: OK. Thank you.

Pat Brooks: Thank you. This is Pat Brooks again and I'll begin talking on slide three on ICD-10 implementation.

On October 1st, 2013, we will be implementing ICD-10 nationally. The compliance date for the implementation of ICD-10-CM is for diagnosis and ICD-10-PCS procedures. Once again that's October 1st, 2013.

There will be no delays on this implementation period and no grace period. A number of you have contacted us about rumors you've heard about a postponement of that date or changes to that date, but I can assure you that that is a firm implementation day.

ICD-10-CM, the diagnosis part, will be used in all settings. ICD-10-PCS, the procedure part of ICD-10, will only be used for inpatient procedures.

Slides 4 thru 30

Going to slide four, we'll discuss how that implementation date will work. The single implementation date of October 1st of 2013 is for all users. The date of services will be used for ambulatory and physician reporting. For instance, if you're in an ambulatory setting and you provide services on or after October 1st, 2013, you will use ICD-10-CM diagnosis codes for that service.

If you are in the inpatient setting, then we will use the date of discharge for ICD-10 implementation. So, for inpatient discharges occurring on or after October 1st, 2013, you will use ICD-10-CM for the diagnosis as well as ICD-10-PCS for procedure coding.

On slide five, you will see that ICD-9-CM codes will not be accepted for services provided on or after October 1st, 2013. Furthermore, ICD-10 codes will not be accepted for services prior to October 1st, 2013.

Slide six discusses the fact that there will be no impact on CPT or alphanumeric HCPCS from ICD-10-CM and ICD-10-PCS. CPT and HCPCS will continue to be used for physician and ambulatory services.

Slide seven shows some of the many benefits of using the ICD-10 coding system with its greater details and more specificity.

The system will be much better for gathering data for measuring the quality, safety, and efficacy of care; for designing payment systems and processing claims for reimbursements; for conducting research, epidemiological studies, and clinical trials; setting health policy; operational and strategic planning, and designing health care delivery systems; monitoring resource utilization; improving clinical, financial, and administrative performance; preventing and detecting health care fraud and abuse; as well as tracking public health and risk.

Looking on to slide eight, we'll discuss some of the differences between ICD-9 and ICD-10 that you'll need to focus on as you're planning your move to ICD-10. ICD-10 codes are different from ICD-9-CM codes. They give much greater detail in describing both the diagnoses and the procedures.

There are more ICD-9 codes than there are ICD-9-CM codes. The ICD-10 codes are longer and they use more alpha characters. Obviously with such differences, we need system changes to accommodate ICD-10 codes.

Post Call Clarification: This was an inadvertent misstatement. There are more ICD-10 codes than ICD-9-CM codes.

On slide nine, you'll see the difference in the number of codes. The diagnosis codes for ICD-9-CM, there are about 14,000 codes that you see on the slide, whereas ICD-10-CM diagnosis codes have about 70,000. For the procedure

codes, ICD-9-CM has about 4,000 codes, where ICD-10-PCS has about 72,000.

Slide 10 discusses some differences in structure. The left side of the slide shows ICD-9-CM diagnosis codes and the right side shows ICD-10-CM diagnosis codes.

Starting with ICD-9-CM, these codes currently have three to five characters. And you'll notice on the right-hand side that ICD-10-CM will have three to seven characters. So there will be more characters. ICD-9-CM has a first character that_s for the most part, numeric, although there are some alpha characters, an E and a V.

ICD-9-CM characters two through five are all numeric and they have at least three characters. When you look at the ICD-10-CM side of the slide, you'll see that the character one for ICD-10-CM is all letters and they're all used except for the U. Character two is numeric and characters three through seven are alpha or numeric.

And occasionally, there's a use of a dummy placeholder, an x. I'll mention one important concept of ICD-10-CM. All the characters that are used, including the x, are not case-sensitive. So they don't have to be capital letters or small.

The last issue mentioned on this slide is that we use a decimal after the first three characters for ICD-9-CM. And you also may want to put a note on the right side of your slide for ICD-10-CM that a decimal is also used after the first three characters on ICD-10-CM.

Slide 11 shows some common codes that many of you on the line are familiar with now, from a three-digit COPD code, that 496, down to an example of a five-digit code for Hepatitis B carrier. And you'll notice the use of the V that we mentioned earlier and the decimal after the first three characters.

We'll move on to slide 12, which illustrates the different look of an ICD-10-CM code, where the codes can be as short as a three-digit, to as long as seven.

We give you an illustration of A78 for Q fever, which is only three digits long, and then move on to a five-digit code for Lyme disease, unspecified. And you'll notice the decimal after the first three digits.

And carrying on, you'll see an example for the physical abuse complicating pregnancy first trimester, which is six digits long. And we end up with a fracture code with the ICD-10-CM that's seven digits long. And once again, notice the use of the alpha characters and the decimal. And the alpha characters do not – are not case-sensitive.

Slide 13 covers an outreach call that we had on ICD-10-CM. Since diagnosis codes are used by all providers, there was a great deal of information – interest in what ICD-10-CM was all about. We have an outreach call on March 23rd, 2013 that was the basic introduction to ICD-10-CM.

Post Call Clarification: This was an inadvertent misstatement. The call was in 2010.

For those of you who do not hear this call, we did get great feedback on it and I would encourage you to listen to the audio or review the written transcripts for these calls. And I give you a site where they are posted. It'll be under the Downloads for the 2010 conference calls.

And it does give you very good detailed information on what ICD-10-CM is all about, much more than I'm going into today.

We move on to slide 14, where I illustrate some differences between the ICD-9-CM procedure codes versus the ICD-10-PCS procedure codes. And you'll note that ICD-9-CM has three to four characters, whereas ICD-10-PCS always has seven characters.

ICD-9-CM is all numeric, whereas ICD-10-PCS can be alpha or numeric. We don't use the numbers – we use the number zero through nine, and do not use the letters zero and I. And that's to avoid some confusion with the numbers zero and one. The ICD-9-CM uses a decimal after the first two characters. ICD-10-PCS will have no decimal.

Post Call Clarification: This was an inadvertent misstatement. The speaker meant to say the letter –O" not zero.

Slide 15 just illustrates an example of a three-digit procedure code versus the more common four-digit procedure code for the suture of the duodenal ulcer site.

Moving on to slide 16, I show an illustration of the seven digits or characters used in ICD-10-PCS. And you'll see the greater use of alpha characters. You'll see that there is no decimal used. ICD-10-PCS is only used in the inpatient hospital settings, so those of you on the phone who work at an inpatient setting will want to learn more about ICD-10-PCS. Those of you who work in physician or ambulatory care will not be using this new procedure coding system.

Slide 17 shows where you can find out more information about the complete ICD-10-CM and ICD-10-PCS coding systems. We post the complete updates with the alpha index and the tabular each year when we update them. And I give you that website. Right now, we are working off the 2010 ICD-10-CM and ICD-10-PCS code updates.

Later this year, we'll be posting the 2011 update. On this same page, we get into some mapping issues that we post and there's a great deal more information about this coding system posted at that website.

The second website that I mention concerns the maintenance and update of both ICD-9 and ICD-10. Both coding systems are maintained through public discussions at the ICD-9-CM Coordination and Maintenance Committee. This committee meets twice a year. And I've provided a link for you that if you want to review summary reports from previous meetings or if you're interested in attending the next meeting, which will be September 15th through the 16th, 2010, in the CMS Auditorium.

And as I will discuss later, we also provide limited calls for you to call in. But this vehicle, the ICD-9 Coordination and Maintenance Committee, is the vehicle we use to maintain both coding systems.

We'll move on to slide 18 and discuss a tool we developed since ICD-9 and ICD-10 are so different. We developed what we've referred to as the General Equivalence Mappings, or the GEMs, to assist in converting data from ICD-9-CM to ICD-10.

Some people refer to these as crosswalks, others call them mapping. But they're basically forward and backing mappings between the coding systems. For instance, you can start with an ICD-9 code and use the mappings to convert to the appropriate ICD-10 code or codes. Or conversely, for the backward mapping, you could start with an ICD-10 code and map back to an ICD-9 code.

Information on these GEMs, the mappings, and their use can be found on our ICD-10 page. Click on the appropriate one you want to map from, either ICD-10-CM diagnosis or ICD-10-PCS, to find the most recent GEM.

If you're interested in converting diagnosis codes, then you'll click on the 2010 ICD-10-CM link. If you're interested in converting procedure codes, you'll click on the 2010 ICD-10-PCS link. All these links, you will also find a GEM user guide that helps you understand how to use the GEMs.

Furthermore, we've already at CMS used the GEMs to do a massive conversion project, converting our Medicare Severity Diagnosis Related Groups, or MS-DRGs, from ICD-9 codes to ICD-10 codes. And we call that the MS-DRG Conversion Project.

We posted extensive files on the web page showed on slide 18 to describe the logic of the ICD-10-based MS-DRGs. We also have a paper that describes the methodology we used in doing this conversion project and we have a detailed description of suggestions on how others that were conducting similar projects should go about doing a conversion project.

I should mention that this conversion project is not final. Any final ICD-10 MS-DRGs would be subject to final rule making.

Slide 19 refers you to a call for those of you who are interested in learning more about the GEMs and perhaps have a project you want to undertake. We had a call on May 19th, 2009, on ICD-10 implementation and the map, the GEMs. And I give you the website.

You would look under the Downloads for the 2009 ICD-10 Calls and you'll find the audio and written transcript for this call so you can learn much more detail about the GEMs.

On slide 20, we mention a very important point. Some of you won't be converting data. You'll simply be learning how to code with ICD-10 and the GEMs are not a substitute for learning how to code with ICD-10.

Everyone will have to use ICD-10 and the GEMs are not a substitute for that. And frankly, for some of you who have small projects with just a few codes, you may not want to bother with the GEMs, it‘s probably just quicker to pick up an ICD-10 code book and use that instead of the GEMs.

I‘ll mention one other issue that's not in these slides but that will be on our website for the ICD-9 Coordination and Maintenance Committee is an important issue that we'll be discussing at our Wednesday, September the 15th, 2010 meeting.

Section 10109(c) of the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 or PPACA requires the Secretary of Health and Human Services to task the Coordination and Maintenance Committee to convene a meeting before January 1st, 2011 to receive stakeholder input regarding the crosswalk between ICD-9 and ICD-10, which is posted on CMS's web page.

And the purpose of this is to make appropriate revisions to the crosswalks and the GEMs as necessary. Section 10109(c) further requires that any revised crosswalk be treated as a code set for which a standard has been adopted by the Secretary. And the revisions to this crosswalk will be posted on the CMS website.

All of this statement and more information will be posted on our CMS website soon, and we will discuss how this issue will be discussed from 9 to 12:30 on Wednesday, September the 15th, 2010 at our ICD-9 Coordination and Maintenance Committee.

Those of you who can attend and want to discuss the maintenance for the GEMs should come and those who can't come and who have comments you would like to provide, you will be given an opportunity to submit additional written comments by November 12th, 2010.

And as I said earlier, all this information will be on our ICD-9 Coordination and Maintenance Committee website in the near future.

Moving on to slide 21 is another issue of importance to many people and that's code freeze. Annually, we update both the ICD-9 and ICD-10 codes. And there has been some discussion of a need for a possible freeze of these updates. It's been an agenda item for the recent ICD-9 Coordination and Maintenance Committee meetings and you can read about this in the summary reports of prior meetings.

Many providers have told – and vendors and others have told us that the annual code updates to both ICD-9 and ICD-10 make transition planning difficult. Vendors, systems maintainers, payers, and educators have requested a code freeze. This would provide them with more time to focus on system conversions and learning about ICD-10.

And the question is, should ICD-10-CM and PCS and/or ICD-9-CM be frozen prior to implementation? And if so, when should the freeze begin?

On slide 22, I show you a place where you can read prior summary reports where this issue was discussed. Based on the discussions at these two prior meetings, the consensus has result – has been around the proposal which we will discuss now.

Looking at slide 23, many of our commenters feel that the last regular annual update to both ICD-9-CM and ICD-10 should be made on October 1st, 2011.

Furthermore, they've requested that only limited ICD-9-CM and ICD-10 updates be made for new technologies and new diseases only on October 1st, 2012.

Then, for October 1st, 2013, there will be only limited new codes for new technologies and diseases for ICD-10. Obviously, on October 1st, 2013, there would be no more ICD-9 codes updated because ICD-9 would be not in effect at that point for services provided.

Then the proposal is that regular updates to ICD-10 would begin again, regular updates, on October 1st, 2014.

On slide 24, you'd see that we plan to make a final decision on any code freeze and announce it at the September 15th through the 16th, 2010 ICD-9 Coordination and Maintenance Committee.

We are continuing to receive comments on this issue. You can read information about the meeting, including an agenda which we posted by mid-October as the website mentions. And you can register to attend this September meeting beginning on or after August the 10th, 2010, or you can participate by conference lines. We will have a limited number of lines for those who want to call in.

On slide 24, you will see that the major professional coding organizations recommend that intensive coding training should not be provided until about six to nine months prior to implementation.

So you should be thinking about January to May, 2013, you'll be wanting to train your own staff. Currently, you should be focusing on other activities. All providers should learn about the structure, organization, and unique features of ICD-10-CM.

Inpatient hospitals should focus on ICD-10-CM and they should also learn about the structure, organization and unique features of ICD-10-PCS. And then everyone should learn about the systems impact of 5010, which we'll be discussing shortly.

Beginning on slide 26, we provide a number of very valuable CMS resources. The first one is general information of ICD-10. The second one, I've already mentioned, the MS-DRG conversion project. And the third one, which Chris will be going into more, is the resources for 5010.

Slide 27 just tells you places where you can get a lot of resources, such as very good fact sheets. And the second part of slide 27, all the CMS Sponsored Calls, such as the one today where we post after the call within a few weeks, written and audio transcripts. And do remember that these are subdivided by the year they're provided.

Slide 28 gives you some more resources that you can click on to see valuable fact sheets that will be helpful to you.

Slide 29 just tells you the kinds of things on the ICD-10 website. So all of you should just browse through these websites and see the kinds of things that are available.

Slide 30 shows two websites that outside organizations provide, and these allow groups to report resources, ICD-10 resources that they have. WEDI and HIMSS, if their members want to, they will list resources, such as encoders, billing software, whatever, they can report from there so that you can look and see what kind of ICD-10 information is available.

And thank you very much. That's the end of my ICD-10 presentation.

Hazeline Roulac: Well, thank you, Pat.

It's my pleasure now to turn the call over to Christine Stahlecker.

Slides 31 thru 48

Christine Stahlecker: Thank you.

Good afternoon everyone and welcome to the second half of our audiocast. I'm Chris Stahlecker and I'm going to be speaking to you about Medicare Fee-For-Service. That's what the FFS is on the title slide, slide 31.

Medicare Fee-For-Service implementation of the transaction versions that are 5010 and D.0. I know that this is a little bit of an overview, but hopefully, those that are going to participate in the Q&A session will have some interesting aspects of their implementation and others might learn from questions that come up.

So on to slide 32, a little bit of an overview, what was adopted under the HIPAA EDI modification rule? It was the version 5010 of the electronic standards, the X12 Standards for administrative transactions. That would be the claim, the eligibility inquiry response, the claim status inquiry response, the remittance advice in the Medicare Fee-For-Service world.

There were additional transactions adopted, of course, under HIPAA, but Medicare Fee-For-Service only uses those core four transactions. This is the update from the 4010 version to the 5010 version. And on the NCPDP or National Council for Prescription Drug Program, the version is being upgraded from 5.1 to D.0.

In general terms, who's affected by all of this? It is the definition of HIPAA covered entities. That means the providers, as well as the health plans and clearinghouses.

However, at this time, due to some other regulations, business associates are also now defined as a covered entity. So, the business associate, the billing agents, service agents, vendors that process claims, take a paper claim and turn it into an electronic claim. Anyone servicing a provider in that nature would be considered affected and falls under compliance of a covered entity definition.

The high level general compliance date for this part of the regulation? Well, it‘s mandatory compliance on January 1st of 2012 for all covered entities.

There are some interim dates that have been supplied in the rule, and internal testing was to begin on January 1st, 2010 and external testing is to begin on January 1st of 2011.

Another way of looking at that term external testing is what Medicare Fee-For-Service is defining that as the beginning of our transition year. So, those that would be ready to complete their testing very early in 2011 may transition to the 5010 version at that time.

On to slide 33, why was this rule adopted? Well, 4010 is essentially outdated. It's probably more like 10 years old and some of the situational and required definitions of data content were incredibly outdated. So that has been addressed under 5010.

In addition to that, there are some structural and data content changes in the transactions. And during the time between when the first version of HIPAA transactions were implemented and today, almost 500 change requests have been received and addressed in the new version.

Some of the ambiguities about when a data element needed to be populated, that's what situational rule means. Those have also been addressed to give more consistency and more definition about when a data element must be populated.

On slide 34, the same notion applies to the NCPDP version, the 5.1 version of NCPDP. It is old as well, and it also had a number of changes submitted to improve it. But it also needed to address the MMA, the Medicare Modernization Act, and the prescription drug improvement, so some of those modifications have been addressed in this new version as well.

On slide 35, what are some of the benefits of converting to 5010 and D.0? Well, the Implementation Guides have removed this ambiguity. So, it should be much more consistent across the payers of how they are receiving these transactions and processing them. So, it should offer some consistency of processing to providers and clearing houses.

Now, I did want to make note that Implementation Guides have a new name. They're called TR3s standing for Technical Report document 3. And so, you'll hear those terms used interchangeably, Implementation Guide or TR3. There are some enhanced usability of certain transactions, such as the referrals and authorizations. There are some improvements to the utility of the NCPDP standards.

These new versions of the standards will support standardization of companion guides across the industry. With the removing of the ambiguities, it does lead towards more consistent, and potentially, at some future date, single companion guides. And it does increase the use of EDI between covered entities.

One of the key data content changes is the Present on Admission indicator. In the current version, there was not a unique home for this indicator. And in the X12 5010 transactions, it does now have a particular data element definition, its own unique data element definition.

On slide 36, essentially, the 5010 project becomes a prerequisite for the ICD-10 project. And why do we say that? Because the current version of the 4010 formats do not permit the use of the ICD-10 code sets, the PCS or the HCPCS codes. So the 5010, you must first convert to the 5010 format in order to be able to use the ICD-10 code set.

When Medicare Fee-For-Service started its project, we took a particular approach so that we would increase the field size for the ICD-10 codes from the minimum of three bytes to the maximum of seven bytes. Pat spoke at length about the size of the field changing in the ICD-10 versions.

And so, in our 5010 implementation, in Medicare Fee-For-Service, we made that expansion to the larger data element size, the seven bytes.

In Medicare Fee-For-Service, in our suite of systems, you'll know that some researchers or analysts that study trends and Medicare data do receive some of our historical files, or access to our historical files. We felt that it may be important years from now to know if one of those minimally-sized code

values, one of those three-digit code values on a historical claim was based on the ICD-9 version of code or the ICD-10 version of code.

So in Medicare Fee-For-Service, we've added one digit that would accompany the ICD – the diagnosis code throughout our systems. That digit will be used to indicate whether or not the ICD code was drawn from the version 9 or version 10 code set.

An additional change was made in the Medicare systems to process the maximum number of diagnosis codes. In today's world, although the institutional claim, the 837 I transaction, in the Medicare Fee-For-Service program systems for Part A, does accommodate 25 instances of the diagnosis code in the 4010 version, our process is only based on 9 iterations. And so, with our 5010 expansion, we are going to process all 25 iterations.

On the professional side, our Medicare Part B side, we will also process the maximum number of diagnosis codes that can be accommodated on an 837 Professional Claim in the 5010 format. That max is 12 iterations. Currently, we're processing only 9. So, that expansion is going to take place.

Just to differentiate though, 5010 and ICD-10 are two separate projects. They have different timelines, and we'll look at that in just a moment. So, with our 5010 project, we are not adding any processing of the ICD-10 code values. We are not including any crosswalk of ICD-9 to ICD-10. And clearly, we will not require the use of ICD-10 codes at the conclusion of our 5010 project.

All of that work, that's not being done with 5010, will be, part of the ICD-10 projects. So, although the format, the 5010 format, permits both the ICD-10 code values and the ICD-9 and the ICD-10 codes, only ICD-9 will continue to be processed up until the ICD-10 project permits ICD-10 codes to come in.

So, all of the business rules saying when the ICD-10 code must be used, and Pat did talk about a number of them, are being defined as part of the ICD-10 project.

On slide 37, the HIPAA legislation mandates that when electronic transactions are used, they must follow a standard. And 5010 is the very first upgrade from the first version of HIPAA EDI standards. The first version being 4010 and/or 4010A1. This project, Medicare Fee-For-Service 5010, is essentially an infrastructure upgrade. It prepares for ICD-10; it gets all of the transactions that Medicare currently exchanges converted from 4010 to 5010.

We are also implementing, instituting some standard acknowledgement and error rejection transactions. And these are identified on slide 37—the functional acknowledgement transaction 999 is going to replace the currently used transaction, which is the 997 transaction.

Under our 5010 project, we are also implementing a Claims Acknowledgment transaction. That's a 277CA for claims acknowledgements. And that will be used to replace proprietary error reporting. That will be very important to those of you that are exchanging EDI transactions. There are number of additional process improvements that Medicare Fee-For-Service is making, including improvements to our receipt control and balancing, standardizing our errata.

In slide 38, what will you need to do to prepare for the 5010 implementation? In terms of general information, please note that the Implementation Guide must be purchased by you. The first time HIPAA was implemented, they were made available to you for free. But that's no longer the case.

So, in order for you to purchase the Implementation Guides or Technical Report 3s, TR-3s, a number of websites are listed here in slide 38. You may also want to review the technical comments, X12 responses to technical comments that have been submitted regarding the upgrade of these transactions, and the website is listed here.

And, finally, on this slide, if you find the need to submit changes for these to be applied to these transaction sets; if you are finding some difficulty that you believe requires a data content change, you may submit it to the DMSO website listed on slide 38.

On slide 39, what else must you do or should you do to get prepared now? Well, first of all, know what needs to be changed. We're saying to you today, reminding you, that the format currently used must be upgraded. So, anyone who is submitting an electronic claim, I've mentioned them before, either the institutional claim, Medicare Part A, or the professional claim Medicare Part B, or a DME Claim, must be changed from the current version to the new version, 5010 and D.0. All of the systems that enable providers to submit those claims must be upgraded to be able to output these new formats. Remittances, those of you that are receiving an electronic remittance must upgrade your systems to receive the new 5010 version of the electronic remittance.

We would suggest that you could also do some analysis in your environment; the software products that you use in your billing systems, your accounts payable or receivable systems, your eligibility, your reception areas, or your appointment scheduling areas. Please have a look at the application systems that you're using in those environments and know that if you are using them in an electronic fashion, that likely, those formats will need to be changed.

To assist you in recognizing the scope of change for 5010, Medicare Fee-for-Service has performed a comparison of the 4010 format and the 5010 format. We've highlighted the data with content changes, and they can be found on this website on slide 39.

So, again, to repeat, the software that you maybe using to produce and exchange these formats must be modified, or enhanced for the new version. And that my require business process changes on your part because in some cases, the data elements have changed. There are new data elements that are required, and in some cases, existing data elements are no longer permitted to be exchanged. So, having a look at this data element comparison may really help you.

On slide 40, again, what you could do to become prepared. Know what resources are available to you for Medicare Fee-For-Service. And some of our educational materials are ready now, and you may access them on the

websites listed here today on slide 40. We have educational materials such as MLN Articles, some fact sheets, and some checklists.

You may also check our 5010 D.0 project website. We have some technical documents listed there. We go in great detail to express the data edits that will be applied to claims, and if we find an error, the actual error code value that will be returned to you to explain the error that is found in claims that you have submitted to us.

We also have some News Flashes. And so, you might want to subscribe to some of the listservs. We've listed where you might go to do that on slide 40.

On slide 41, again, know what resources are available to you. Please know that we've had a series of national provider calls, educational calls, specific to the Medicare Fee-for-Service implementation of 5010 transaction upgrades.

We've already conducted the Eligibility Request/Response audiocast, and the Professional Claim audiocast. On June 30th, we are scheduled to deliver the Institutional Claim audiocast, and you can subscribe to a listserv and learn how to register and attend that audiocast. We have listed here the future audiocasts that will be delivered. And I just wanted to note that we are inserting one between September and October on the NCPDP transaction changes.

These presentations all have transcripts and recordings and we've listed the site where you may go to have access to those sessions that were already delivered.

On slide 42, are additional suggestions that we have for you today. We‘re suggesting that you contact your system vendor and find out if your license with that vendor includes a mandatory regulation update. So, perhaps, you've already incurred the maintenance fee to receive a regulation update. If not, you probably need to take budget steps to obtain funding to purchase an update.

We're suggesting that you also ask your vendor if the upgrade is going to include the new acknowledgment transaction, the 277 Claims Acknowledgment and the 999. I want to make note that the 277 Claims Acknowledgment is not a HIPAA standard. This is Medicare Fee-For-Service implementation of improvements to the Medicare EDI environment.

We want to eliminate our reporting capabilities. We will no longer send back to billers a report format. We'll send back a transaction format. So, it will be a responsibility for your clearinghouse or your vendor who supplies your exchanges for sending in claims and receiving back errors to accommodate receipt of the 277 Claims Acknowledgment and turn that into a human readable report for you.

So, this is an excellent question for you to ask your vendor. CMS has conducted outreach for over a year now on that very point to make sure the word was out early to vendors so that they understood that they needed to take that step on your behalf.

Please inquire, the middle bullet here, when your vendor is planning your system upgrade. Please make sure that it will be timely so that you're not affected and caught in a flurry of activity late in 2012 or 2011 just before the cutoff. You want to make sure that your installs of your system upgrade will happen early enough in 2011 so that you can complete whatever testing you want to and be assured of a smooth and seamless transition.

And, finally, to have a look at your routine operations and begin planning for your staff, billing office training, and transition activity.

On slide 43, the timeline, it is brought home to roost. Today is the Ides of June. We're midway between January 1st, 2010 and '11. And we are to be completing in this calendar year, all of our systems and integration testing.

Medicare Fee-For-Service began its implementations of software enhancements on October 1st of 2008. So that was our very first software install for our 5010 implementation. We have been incrementally making software installations into our production environment since that time.

We had concurrent development and production installation throughout calendar year of 2009. And at this point, in calendar year 2010, we are completing the integration testing. So, we're testing our Front End Systems delivery to our core systems. An example of that would be our Medicare Part A processing system and Medicare Part B processing system, and interfacing those test files through our downstream national claims history repositories, to make sure that anyone using Medicare data is able to receive the enhanced versions and that an entire suite of systems that make up our Medicare process are fully integrated and able to execute. That‘s what's going on in the calendar year of 2010. That says to you that January 1st 2011, Medicare Fee-For-Service will be ready to begin processing and receiving 5010 transaction formats. That gives the Medicare Fee-For-Service providers a full year to complete their transition.

So it's not too early for you to be asking your vendors when they're going to be giving you your installation software so that you might begin your transition activity. Pat spoke about when the ICD-9 cut off will happen, the 4010 format will no longer be processed on January 1st of 2012. That allows a year and a half to transition to ICD-10; as an opportunity for all of our system changes to quiet down before the ICD-10 cutover happens on October 1st of 2013.

On slide 44, just to say it again, Medicare Fee-For-Service had an incremental development approach for our 5010 software. The 4010 format will be continued to be processed right up until January 1st, 2012, but please don't wait that long to begin your 5010 transition. If there are a large number of remaining billers that late in the year, it will be very difficult for MACs to transition them into production submitters by the deadline.

We are currently performing integration testing and regression testing has been continuing since that October 1st 2008 date as the software components were incrementally put into production. We wanted to make sure that nothing was broken and that was the point of the regression testing.

Now that we have all of the software components in place, we are beginning to go back and do an intensive beta test of those software components. That is also happening concurrently with the integration test.

The certification test is a new activity along with 5010. Medicare Fee-For-Service is going to require each of its Medicare Administrative Contractors to undergo a certification test before they begin transitioning their trading partners. The certification test is scheduled to begin by the MACs on October 1st of 2010 and to be concluded by December 31st of 2010.

Once it's concluded, Medicare Central Office will indicate to that MAC that they are in shape. They're permitted to begin the transition work for their trading partners, the providers who actually submit the 5010 production formats. Providers that are interested in testing that 5010 transaction should contact their Medicare Administrative Contractor.

If you happen to be a provider in a geographical area where Medicare has not completed its transition to a MAC, that means that you are still exchanging transactions with our legacy contractors known as Fiscal Intermediaries or carriers. You may want to contact them to find out when you will be able to submit your 5010 test transactions.

Medicare Fee-For-Service has taken steps so that even if our MAC is not in place, the providers and billers are not inconvenienced. You too will have the full calendar year to complete your transition to the 5010 format. Your current legacy contractor, your Fiscal Intermediary or carrier can help you understand how that will be supported.

Moving on to slide 45, what happens if providers do not complete their transition? Well, if you're not ready to submit a 5010 transaction on January 1st of 2011, that's OK. You can submit your 4010A1 transactions until you are ready sometime during 2011. But if you're not ready by January 1st of 2012, you will no longer be able to submit electronic transactions.

Providers that are submitting paper claim forms today should not experience a change in that claim form for 5010 or the ICD-10 projects. Our understanding

is at this time those paper claim forms can already accommodate the additional length of the diagnosis. On the institutional paper claim form, the UB-04, they also include an indicator, a zero or nine, to say whether or not there‘s an ICD-9 or 10 code value.

On slide 46, the Institutional UB-04, also known as the CMS-1450, is owned and maintained by the National Uniform Billing Committee (NUBC) and the ICD-10 updates for this form are done. No changes will be made to enhance the paper claim form to accommodate the 25 diagnosis codes. If more codes are needed, you have to submit that claim electronically.

The same situation applies for the Professional Claim, also known as the CMS-1500. That claim form is owned and maintained by the National Uniform Code Committee (NUCC), and the ICD-10 updates are done. CMS has submitted a request to have the paper claim form enhanced to accommodate the 12 diagnosis codes, but that will not be completed, before you need to swing over to the 5010 version of the electronic claim, so the paper claim will not be enhanced to accommodate the additional diagnosis codes before January 1st of 2012.

On slide 47, some additional support is still offered in terms of the free billing software that will continue to be made available to the Medicare Fee-For-Service Part A and Part B providers. Claims submitted using this free software are HIPAA compliant. There is a reference to this in the Medicare Fee-For-Service Claims Processing Internet-Only Manual in chapter 24.

There is free claims submission software along with remittance advice print software. We do have two different products for the remittances. One is called, for the carrier side or the Medicare Part B side, it's called Medicare Remit Easy Print. And on the Medicare Part A side, it is called the PC Print software. And more information can be found at these websites.

On slide 48, the claim submission software that will be for the 837 transaction for both Medicare Part A and Part B will be supported using the PCAce, or Pro-32 software. Both of the versions, the Part A side and the Part B side, will both be upgraded to accommodate the 5010 format.

In addition, those products will be upgraded to receive the new 277 Claims Acknowledgment transaction and produce a human readable error report for you as well as process the 999 transaction. I believe the other information on this slide refers to the Medicare Easy Print software and PC Print software that I've already spoken about.

Now that concludes the information that I wanted to speak to you today about. And I'm looking forward to whatever questions you might have during the Q&A session. I'll turn it back over to Hazeline.

Question and Answer Session

Hazeline Roulac: Thank you, Christine. We've now completed the presentation portion of this call and we will move on to the question and answer session. But before we begin, I just want to draw your attention to slide 49, 50 and 51. For those who came into the call late and missed the introduction, you may be eligible to receive continuing education credit through the American Academy of Professional Coders or the American Health Information Management Association. Please read the two statements on these slides. These statements were provided to us by the respective organizations. If you have any questions concerning the statements, please contact the respective organizations and not CMS.

I want to remind everyone that this call is being recorded and transcribed. Before you ask your question, please state your name and the name of the organization you are with. In an effort to get as many – to get to as many questions as possible, we ask that you limit your question to one. All right, Christopher. I think at this time we are ready to open the lines for questions. We have a lot of time so I hope you have a lot of questions. Our speakers are ready to answer your questions.

Operator: We will now open the lines for the question and answer session. To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, please press the pound key. Please state

your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note that your line will remain open during the time you are asking your question so anything you say or any background noise will be heard in the conference. Please hold for your first question.

Your first question comes from the line of Donna Miller. Your line is now open.

Donna Miller: Thank you. My question is a simple one. How much will the Implementation Guide cost the providers?

Chris Stahlecker: Hi. It's Chris. I'm afraid you'll have to go to the website and obtain that information. It‘s not a cost that CMS is involved in, in any way. It is a cost that is totally involved with the Standards Development Organization who is producing this on behalf of the entire industry, not just for Medicare. The transaction standards apply for all payers. The cost to us wouldn‘t be meaningful to you because we received a volume discount. We needed to supply copies to a number of folks. .

Donna Miller: All right. Thank you.

Operator: Your next question comes from the line of Leslie Whitkin. Your line is now open.

Leslie Whitkin: Hi. This is Leslie Whitkin at Physicians First in Orlando, Florida. Could you give an example of a new data element that will be required under 5010 and a data element that would no longer be allowed?

Chris Stahlecker: I can only give you some descriptions. Some of the amounts for Medicare covered amounts or allowed amount – not the allowed amount but the Medicare paid amount I believe. I'm not going to get the correct answer for you but there are some calculations that are now required to be applied after Medicare makes its primary payment and before the claim is crossed over. I believe it's in large measure in those areas where there are some data elements

that are no longer present on the claim. So if you know where that location is in the claim, it will be highlighted in our spreadsheet.

An example of an element that was not present in 4010 but is in 5010 is the Present on Admission indicator. That's the one that is most meaningful. In the 4010 version, they needed to find an element that was simply available and had a text definition and they took that string of spaces and gave it a definition, so that if there were multiple Present on Admission diagnoses you could represent it.

But in the new 5010 format, the Present on Admission has a unique data element with definitions about how to populate it. So, I think you'll find both of those defined in our crosswalk between the 4010 version and the 5010. There is a separate one, by the way, for the 837 Institutional Claim from the 837 Professional Claim. Those are the two claim types of claims Medicare uses for X12.

Leslie Whitkin: So, we're not talking basic things like date of birth and changes to data elements like that.

Chris Stachlecker: No, we‘re not.

Leslie Whitkin: OK. Thanks.

Chris Stachlecker: Yes.

Operator: Your next question comes from the line of Deborah Farley. Your line is now open.

Deborah Farley: Yes. I'd like to ask for clarification. On page four, the last paragraph it says "date of discharge for inpatient settings. Inpatient discharges occurring on or after 10/1 will use ICD-10.” Now is that the discharge date or the whole hospital stay including the discharge date?

Pat Brooks: This is Pat Brooks. That is the actual discharge date. So, if a patient is admitted in September of 2013 and discharged on October 1st 2013, they would be covered by the ICD-10 implementation. So you look at the date of

discharge to pick the version of the coding system to use. And in fact, that is consistent with the way we do ICD-9 now, when we do the annual updates in October 1st. The hospitals use the updates in effect on the date of discharge so we're trying to be consistent moving to ICD-10.

Deborah Farley: So, that means we'd use the ICD-10 for the whole hospital stay on that claim from September…

Pat Brooks: Yes.

Deborah Farley: Pardon?

Pat Brooks: Yes, that's correct. When you code that discharge summary, you would – that occurs on or after October 1st 2013, they would all be ICD-10 codes.

Deborah Farley: Oh, OK. Thank you so much.

Operator: Your next question comes from the line of Shelley McCash. Your line is now open.

Shelley McCash: Hi, Shelley McCash from Life Care Medical Center. And my question is referring to slide number 25 where it says "Current Activities". And it talks about ICD-10-CM for all provider types and ICD-10-PCS for inpatient hospital. How about outpatient hospital claims, charges – that type of thing for like the ER and lab?

Pat Brooks: Those will continue – the outpatient will continue to use CPT and HCPCS as they do now. There will be no change. They will not be impacted from the procedure side by the move to ICD-10. However, if it's an ER or outpatient, when you use a diagnosis code, you will convert from ICD-9-CM diagnosis codes to ICD-10-CM diagnosis codes. The only one impacted by the ICD-10-PCS, the Procedure Coding System, will be those who code inpatient procedures.

Shelley McCash: OK. Thank you.

Operator: Your next question comes from the line of Jill Zimmerman. Your line is now open.

Jill Zimmerman: Hi. This is Jill Zimmerman from Dubois Regional Medical Center. I wondered if you had any tips or hints for us on how or what education we could start possibly with the physicians or with other departments in our facility. I know that the recommendation is not to train the coders until six months prior. But I wonder if what your feelings were on the other areas?

Pat Brooks: This is Pat Brooks. I think that it's a good idea to give them high level overviews of what ICD-10 is all about and doing so you may just remove some of the myths. Like some myths out there that we're replacing CPT with ICD-10. It would be nice if you went ahead and told them that we're not intending to replace CPT and HCPCS. That would be very helpful. And then for others if you want to talk about that rumor that keeps persisting about we don't really mean the implementation date. Some of the physician community is getting a lot of that rumor that we're not moving forward. That would be helpful.

I can suggest some real good resources for you. We had an outreach call for the physician specialty groups. You can find that on our outreach calls. We developed some slides that we posted there and we suggested those physician specialty groups use those slides to help educate their members. So you could take those slides yourself. And if you wanted to you could revise them and you could use them for your staff.

And I would also recommend if you wanted to you could look at the ICD-10-CM Basic Call we had- that was Sue Bowman from AHIMA who was part of that. You could also tailor that presentation- take those slides and use then for your internal purposes. I guess the real point was just like you don't want to start with coders getting in to the weeds of coding now. You just want to give them an overview flavor of what's it all about at that time and being how to approach it and just hit those rumors that we seem to have trouble dispensing.

Deborah Farley: OK. Thank you.

Operator: Your next question comes from the line of Jane Looper. Your line is now open.

Jane Looper: Hi. I just have a general question regarding the website to view the transcript from today's seminar.

Pat Brooks: OK. Your question?

Jane Looper: Do you have the website?

Pat Brooks: Oh, what is the website?

Jane Looper: What is the website to view today's seminar in transcript version, yes?

Hazeline Roulac: It's www.cms.gov/icd10. And then when you get on the web page on the left side of the page you want to click on CMS Sponsored Calls and then scroll down to the bottom of the page to the Downloads section and you'll see a zip file. It will say 2010 ICD-10 Conference Calls. If you click on that zip file, you will find the audio transcript and the written transcript for some previous calls that have taken place so far this year. The transcript for this call should be there in about two weeks.

Jane Looper: OK. Thank you very much.

CMS: You're welcome.

Operator: Your next question comes from the line of Rebecca Foreman. Your line is now open.

Rebecca Foreman: The question is a simple one, is when will the new ICD-10 diagnosis code book be available for purchase?

Pat Brooks: This is Pat Brooks. Some vendors already have those code books out for purchase. The two slides that I've mentioned before if you want to keep checking those – the WEDI sites and the HIMSS on slide 30 then they probably are – I imagine publishers will list them. I know that right now Ingenix has a code book available and there may be others. And if so, they

probably will be listing all of these websites and perhaps in the AHIMA journal also.

Rebecca Foreman: OK. Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Carol Koser. Your line is now open.

Carol Koser: Hi. This is Carol Koser from Dr. Marcia Turbiner's office. And I want to know if you need to have a minimum number of claims to be able to use the online Medicare program to submit them?

Chris Stahlecker: No, absolutely not. In fact, there's a piece of legislation that requires the submission of electronic claim. Even if you have few claims, you may submit them. You may qualify – to continue submitting paper. But, of course, with these improvements, and especially the free billing software you may want to go electronic.

Carol Kloser: Yes, because I thought I received an e-mail before and they said not to use it unless you are going to consistently have so many and we only have like two or three.

Chris Stahlecker: No, there's some data quality improvements as well as timeliness of getting your payment back that you may prefer with electronic submission. There's a different payment window on electronically submitted claims. So, the process itself may be something that you're interested in and there should not be a minimum number of claims that would prevent you from submitting to one of our Medicare Administrative Contractors.

If you are finding difficulty in that area, we would like to know about that. Your first point of contact, of course, would be to follow up with your MAC. Your second point of contact would be to follow up with the Regional Office.

Carol Koser: OK. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Barbara Greene. Your line is now open.

Barbara Greene: Barbara Greene from PAL Health Care.

I'm curious if there's any particular extra needs for those of us who are Critical Access Hospitals and preparing for these changes.

Chris Stahlecker: Preparing for which set of changes? The EDI claim transaction submission changes or the coding system changes?

Barbara Greene: No, just the whole 5010.

Chris Stahlecker: With critical care, no. The electronic transaction formats would need to be modified. So, you probably have an information technology department doing that work on your behalf. They definitely need to know the details about this project. Or if you're supported by vendors or a clearing house, you would want to be in contact with them to find out what their strategy is and their timeline to support your transition. But all of the formats are changing.

Barbara Greene: OK. Thank you.

Operator: Your next question comes from the line of Jeff Sheele. Your line is now open.

Jeff Sheele: Hi. My name is Jeff Sheele and I'm with Nightingale VantageMed.
My question's about the discontinuation of the allowed and approved amounts in 837P.

Chris Stahlecker: No, no. Please let me take that back. I don't have the details in front of me. And I was struggling to recall what data elements may have changed. I don't believe those are changing.

Jeff Sheele: Well, they are in the 5010 spec, and those have been used for control of payment by Medicare in 4010.

Chris Stahlecker: Right.

Jeff Sheele: So I'm worried…

Chris Stahlecker: No, please don't take that…

Jeff Sheele: When 4010 was implemented a lot of people were overpaid because those weren't calculated.

Chris Stahlecker: No, I'm suggesting that you look at our spreadsheets. And unfortunately, I did not bring a hard copy with me to this conference room so I can't answer the question factually. But I would suggest you go to our website and look at those data elements. There is a crosswalk from the 4010 version to the 5010 version. Then, and only then, would you be concerned if those elements are changing. I do not believe the allowed amount is an element that's changing.

Jeff Sheele: They've discontinued the whole AMT. It‘s not- allowed amount and approved amount is not in 5010.

Chris Stahlecker: OK.

Jeff Sheele: And since that was a limiting factor in Medicare processing of secondary claims, I'm kind of worried that it's missing.

Chris Stahlecker: OK. How can I help you?

Jeff Sheele: I'm wondering what Medicare is going to do alternatively to limit payment. Are they going to calculate that themselves or are they…?

Chris Stahlecker: Medicare always calculates the allowed amount.

Jeff Sheele: The – a lot of the contractors weren't, we were seeing overpayments and had to scramble on when to calculate it ourselves and add it in there.

Chris Stahlecker: If you would like to send me or give me your phone number, we could call you back and discuss this offline.

Jeff Sheele: Sure.

Chris Stahlecker: OK.

Jeff Sheele: My phone number is XXX-XXX-XXXX.

Chris Stahlecker: XXX-XXX, I'm sorry?

Jeff Sheele: XXXX.

Chris Stahlecker: XXXX. And the name again please?

Jeff Sheele: My name is Jeff Sheele.

Chris Stahlecker: Jeff. Thank you.

Jeff Sheele: Thank you.

Chris Stahlecker: We'll call you and get more detail on that. Thank you.

Jeff Sheele: Thank you.

Operator: Your next question comes from the line of Robert Burleigh. Your line is now open.

Robert Burleigh: Hi, this is Robert Burleigh of Brandywine Health Care.

My question is for Christine and it has to do with 5010 and state Medicaid programs. There are some Medicaid programs that are not yet 4010 compliant. And there's a lot of concern among providers that state Medicaid programs will not be ready for implementation of 5010 and the impact that will have on Medicare crossover claims.

Chris Stahlecker: The internal dialogue about what Medicare Fee-For-Service could do to support the Medicaid states continues. And I don't have an answer for you today on that particular question about what's going to happen in those states. I know that the Central Office Medicaid staff is looking at what they can do to support the states. But I don't have an answer for you today.

Robert Burleigh: OK.

Question and Answer Session Continued

Operator: Your next question comes from the line of Chuck Brewster. Your line is now open.

Trish Rowe: Hi. This is Trish Rowe and I'm asking the question for Chuck. He just stepped out.

We would like to know if the MPC CC exclusion list that was not completed on the definitions manual for version 26, will be completed at – sometime soon?

Pat Brooks: This is Pat Brooks, and yes, we are working on that right now. And once we get that part of it finished, we will post that, too.

Trish Rowe: Any expected timeframe for that?

Pat Brooks: You know, I don't have one for you today it‘s just that that is in the works.

Trish Rowe: OK. Thank you.

Operator: Your next question comes from the line of Frank DeMario. Your line is now open.

Frank DeMario: Good afternoon. Thank you for having this call. My name is Frank DeMario. I represent a vendor in South Florida.

And my question is simple. Referring back to, I think it's slide five, this might be for Pat. It doesn't appear that there's a phase-in or transition period between the ICD-9 and ICD-10, is that correct? Is it really a one-day cut off that you expect everyone to stop sending you ICD-9 and then start sending the ICD-10?

Pat Brooks: Yes, you're completely correct. And we do want to stress that that is a hard and fast one, so that beginning on October 1st 2013, the date of service, the

term is hard and fast, the transition. And there won't be any grace period of overlap or anything like that. So those slides are completely accurate. We are very firm of that implementation day for the date of service or for the discharge date for hospitals.

Frank DeMario: OK. So really, what that requires is that all providers maintain almost like a dual system, a 9 and the 10 system and then be able to almost flip a switch, if you will, that says you know, because there's no way that vendors or suppliers would be able to get out updates like you know, in the turnaround period of such a short amount of time. So that will require us to have updates out and ready to go so that the customers could then say, "OK, well, as of this date, I'm flipping a switch," and saying, "I'm sending this to 10s," or like you said, make it based on the service date.

Pat Brooks: It is based on the service date. And you're correct that if some providers are late in sending in their claims for, say, an August discharge 2013 and you receive it in December, since this is August 2013, it will have to be an ICD-9 code. So yes, you'll have to maintain dual systems for the separate date of services.

Frank DeMario: OK. That's good information to know. Thank you very, very much.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line Laura McIntyre. Your line is now open.

Laura McIntyre: Hi. Thank you. I'm Laura McIntyre with Catalina Pointe Arthritis in Tucson, Arizona. And the gentleman ahead of me asked the first part of my question on the date of service. Thank you.

The other part of my question is just sort of a reiteration on the inpatient visits for – the only inpatient services we provide are E&M codes. So we would just use the ICD-10 short list of codes that we use to bill for visits within an inpatient setting.

Pat Brooks: If you're talking about billing for a physician who treats inpatient on physician bills- beginning for his bills, for patients he sees on October 1st, 2013, you will put down ICD-10-CM diagnosis code. And you will continue to put down your CPT codes.

Laura McIntyre: Oh, OK. I did misunderstand that then because it's just that a physician's professional visit, I can still use the ICD-9.

Pat Brooks: Yes, the ICD-9-CM procedure codes are only used on the inpatient setting and so they will be replaced with ICD-10-PCS. Everyone, every provider in every location uses ICD-9-CM diagnosis codes. They will convert to ICD-10-CM diagnosis codes for services that occur on or after October 1st, 2013.

Laura McIntyre: Right, I understand that. I was just asking about the CPT codes, the E&M visit.

Pat Brooks: The CPT codes will continue to be used and…

Laura McIntyre: All right.

Pat Brooks: And just – we won't interfere with that.

Laura McIntyre: Thank you very much.

Operator: Your next question comes from the line of Jodi Kirchner. Your line is now open.

Jodi Kirchner: Yes, hi. I was calling to ask about the conversion of DSM IV for behavioral health settings and how that fits into the conversion to the ICD-10-CM coding system.

Pat Brooks: You know, I can't discuss the separate issue of APA concerning their DSMs, but what I can tell you is that ICD-10-CM diagnosis will be implemented on October 1st 2013. So, and that does have the mental chapter. That's pretty much what I can say. Any questions about separate activity with the American Psychiatric Association, you probably should take them.

Pat Brooks: OK, thank you.

Operator: Your next question comes from the line of Betsy Corr. Your line is now open.

Betsy Corr: Betsy Corr, Wake Forest University Health Sciences. Will CMS be giving any guidance on what a professional provider should do when dates of service span the compliance date either for industry-wide guidance or for Medicare itself? Should they split the claim along the lines of the compliance date? Or in EDI should they send both the 9 codes and 10 codes that apply and then each service line point to the appropriate code set?

Pat Brooks: This is Pat. CMS is working on that issue internally. And we're evaluating it. And we plan to give instructions on that point at some time in the future. We don't have an answer for you today, but it is a very important issue you have raised.

Betsy Corr: Thank you.

Operator: Your next question comes from the line of Stephanie Gibson. Your line is now open.

Stephanie Gibson: Yes, this is Stephanie with Advanced Technologies. And we do DME. How does the transition from ICD-9 to ICD-10 work when we have like a rental of equipment? Would we – if it spans from say September to October, do we just use the ICD-10 or would we have to split the dates up, September dates ICD-9, October dates ICD-10.

Pat Brooks: This is Pat again, just like with the previous requester, on the issue of spans of services covered by a claim over that implementation period, that's an issue that we're looking at now and that we're hoping to provide definitive instructions in the future about how you would handle this, but right now, we don't really have a response to that question.

Stephanie Gibson: OK, I wasn't – I kind of thought that‘s what you would say but at the same time I wasn't sure. So, I was just making sure. OK, so we're still working on how we're going to do it like that, OK.

Pat Brooks: Yes.

Stephanie Gibson: All right, that works. Thank you.

Operator: Your next question comes from the line of Sandra Mitchell. Your line is now open.

Sandra Mitchell: Hi, this is Sandra Mitchell with Radiology Associates of Hollywood. And I'm going back to the definition of inpatient procedures. We're hospital-based radiologists. We perform surgical procedures such as biopsies or stent placement on inpatients in the hospital. So – but we bill as Part B, we bill Medicare Part B. So, would our CPT codes be affected? Is that a definition of an inpatient procedure that – I guess that's what I need clarification of.

Pat Brooks: No, you will not be affected. So, you're billing Part B your billing currently uses CPT HCPCS, you will continue to use CPT and HCPCS.

Sandra Mitchell: Right.

Pat Brooks: And ICD-10 implementation does not impact that at all.

Sandra Mitchell: Great, thank you so much.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Melissa Sissle. Your line is now open.

Melissa Sissle: Hi, I'm with Positive Pathways and we're a mental health practice. And I just have a few questions on how this is going to change the mental health billing part of everything in that aspect?

Pat Brooks: I don't think we can get into specific payment policy issues today. All I can tell you is that, if you report ICD-9-CM diagnosis codes then you would be required to convert to ICD-10-CM diagnosis codes on October 1st, 2013. But on how it will affect payment policy, for that or many other parts of the agencies we can't really respond to that today.

Melissa Sissle: OK, do you if you're going to have anything updated in – for the whole mental health part of this tier system soon?

Pat Brooks: I can't tell you the date of any policy – and payment policy conversion. We did the MS-DRG conversion very early. So, that was very early just to help share with the rest of the country how you would do such a large conversion project. Such work is ongoing and being analyzed throughout CMS and I think through all payers as they decide how they're going to base their payment systems on the new codes. But we don't have any firm timelines to share with you on that work today.

Melissa Sissle: OK, and again, we can go and refer to the, I believe it was called the GEM to kind of change over the codes and see what the new codes would be?

Pat Brooks: That would be an excellent way. So, if you have 10 codes that you use a lot and you were just curious about what they look like in ICD-10, one way to do that would be to look at the GEMs. Another way would be to just simply pull up the complete ICD-10-CM diagnosis code systems on our website. You can look up some terms and see what the pages look like because we have the complete book, if you will, in electronic format right on our website. You could do either way.

Melissa Sissle: OK, all right. Thank you so much.

Operator: Your next question comes from the line of Jennifer Bowman. Your line is now open.

Jennifer Bowman: Thank you and thank you so much for this wonderful classes that you're giving us right now. I'm Jennifer. I'm calling from PIF Home Health Care in Indiana. I'd like to know in the home health arena, what should we be doing now aside from checking with our software companies, for OASIS submissions and things of that nature, and using the ICD-10-CM beginning in October 13th. Are there any transitions that we should be incorporating?

Pat Brooks: Hi you know I would give the same advice to you as I would for all types , all provider types. I think now, just like that slide mentioned, I wouldn't start

detailed coding instruction of ICD-10-CM until you know about six months ahead of time. Right now, you – I would urge you to look at some of the other outreach calls we've got.

The ICD-10-CM Basics Call, which is really good, it'll give you a good idea of what the coding systems are all about. You can review our website just to see kinds of things to think about like Chris mentioned for some formatting issues on electronics issues. You can just get ready to understand the environment. As far as any payment policy changes to home health, those aren't ready yet so you know, we don't have anything for you to look at and change in that regard. But I think you're doing the right thing, listen to our calls and just being aware that – what ICD-10 is all about and how it's different.

Jennifer Bowman: Sounds like we'll have a minimal transition is – is basically what I'm saying. So, I don't think in the home health arena, is going to be as dramatic as what I'm hearing some of the other arenas are going to be experiencing. Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Chuck Brewster. Your line is now open.

Chuck Brewster: I'm Chuck Brewster, again from MedAssets. A real quick question, will they then be producing short descriptions for this new ICD-10 diagnosis codes?

Pat Brooks: Yes, that's a very timely question. We're working on that now, determining the optimal size and we will produce some of them and then we'll post them on our website and that'll be free for everyone to use. But yes, we will produce abbreviated titles.

Chuck Brewster: And for also – for the procedure codes too?

Pat Brooks: For both the diagnosis and the procedure codes for ICD-10, we will be producing those abbreviated titles, yes.

Chuck Bruster: Thank you, thank you.

Operator: Your next question comes from the line of Leslie Gachens. Your line is now open.

Leslie Gachens: Yes, good afternoon, this is Leslie Gachens with Maryland Open MRI. I'm still unable to pull up the slides. Can you give me that site number again, site address?

CMS: Yes, it's www.cms.gov/icd10. Are you able to get to that page?

Leslie Gachens: Yes, but I'm not able to – I'm not seeing a download for the slides.

Hazeline Roulac: OK, once you're on the page, on the left side, you'll see a tab that says, CMS Sponsored Calls.

Leslie Gachens: Correct.

Hazeline Roulac: Click on that tab. Scroll to the bottom of the page, you'll see Downloads.

Leslie Gachens: Yes.

Hazeline Roulac: OK, and then you'll see 2010 ICD-10 Conference Calls.

Leslie Gachens: Correct.

Hazeline Roulac: Click on that zip file.

Leslie Gachens: OK.

Hazeline Roulac: And then once you're on that zip file, you'll see the June 15th, 2010 slide presentation.

Leslie Gachens: OK, because I got the March 23rd.

Hazeline Roulac: OK, it should be...

Leslie Gachens: …at the bottom, all right, but that should be there.

Hazeline Roulac: Yes.

Leslie Gachens: OK, all right. And then, you also made reference to being able to access the ICD-10 codes on your site so we can compare with the ICD-9s. What, would I find that document on the same www.cms.gov/icd10?

Pat Brooks: Yes, yes. This is Pat Brooks. If you look on that main page, over on the left side, and you'll see three-quarters of the way down you'll see something that says for instance, 2010, ICD-10-CM.

Leslie Gachens: OK.

Pat Brooks: And when you click them back, you get all these files we're talking about, the complete ICD-10, it's the GEMs, the mapping styles we discussed, this user guide, it's titles, a lot of stuff there, and similar things on this 2010 ICD-10-PCS page. Each year, when we update these files, we put the new ones, like today for this year is 2010 and we keep the older ones 2009. We're in the process of transitioning now to the 2011 which we'll hopefully have by the end of the year, early next year.

Leslie Gachens: OK, great. Thank you very much.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Gloria Dresse. Your line is now open.

Gloria Dresse: Hi, this is Gloria. And I'm calling from a home health agency in Texas. And I understood the question by the other home health agency, but my question focuses more on the ICD-10 coding and OASIS. And what is CMS doing to update the coding guidelines in OASIS rules and regulations for us to use the ICD-10 in 2013, because our OASIS guidelines right now only allow us to use ICD-9. There are only five spaces and a decimal point to be used in our OASIS documentation. So, what is CMS doing and are we going to hear more by 2013 on how our OASIS documentation is affected by the ICD-10?

Pat Brooks: Yes, this is Pat Brooks again. Once again, all the policy areas within CMS, including home health, are aware that they have to convert their payment system to ICD-10 and they are individually working on it. We're not prepared today to discuss one payment area or another and I in particular don't work in the home health area but I do know that they're working on that. And they will certainly let you know they'll keep you abreast once they work out the details of how they're converting OASIS and how they're converting to ICD-10 as will the other components of CMS who are converting their policy areas.

Gloria Dresse: OK, thank you.

Operator: Your next question comes from the line of Claudia Button. Your line is now open.

Claudia Button: Good afternoon. My name is Claudia Button and I'm with LaFree Physical therapy. And my question is about slides 11 and 12 where you're showing the differences between ICD-9 and the ICD-10. Could you be a little more specific, if I give you a code, would you be able to tell me what it will look like as an ICD-10, because the codes on 11 and 12 are too different and it would just kind of be nice to know what it will look like in the new format?

Pat Brooks: You know – this is Pat Brooks – I don‘t even have an ICD-9 or an ICD-10 code with me here in the room, so I can't give you any more examples than that. But the outreach call on ICD-10-CM basic sounds absolutely like what you're looking for.

That call, I believe it was in March of this year, was excellent. It gave a whole bunch of examples down to the detail level of how things changed and what they look like and examples of things with Xs in them. And I think if you'll listen to that call and look at the slides along with it, you'll get exactly what you're looking for.

Claudia Button: Unfortunately, I was on spring break and could not listen to that call. I wanted to but...

Pat Brooks: No, no, you can listen to it now if you want to because we've posted the audio for that call. You can, after this call, you can – you can download the audio and listen to it and follow along with the slides, and you can get the information today if you want to from that ICD-10 Basics Call.

Claudia Button: OK. Thank you.

Pat Brooks: You're welcome:

Operator: Your next question comes from the line of Daryl Hubbler.

Your line is now open.

Daryl Hubbler: Yes, it's Daryl Hubbler, Peace Health, Eugene, Oregon. A question for Pat, are the same HIPAA covered entities that are defined for 5010 the same for ICD-10?

Pat Brooks: Well, I guess you could say it's broader because everybody that reports codes have to use, have to convert from ICD-9 to ICD-10. So, if you want to bill and use ICD-9 codes now, you won't be able to use ICD-9 for that purpose later. I don't know if that helps you.

Daryl Hubbler: Well, that'd be for you know working with Medicare, but I mean like for our other payers, our other commercial payers and those kind of folks.

Pat Brooks: Yes, they will be converted also because they pay for your bills. They are definitely covered. And they – they're...

Daryl Hubbler: They're required by law then.

Pat Brooks: Yes. And they're working – many of them have found our GEMs and are using those to begin work on converting their payment systems. So I think the other payers are very aware that they have to modify their payment logic to you know, take care of ICD-10. How far along they are will vary by payer.

Daryl Hubbler: Very good. Thank you. Good job this morning.

Pat Brooks: Thank you.

Operator: Your next question comes from the line of Kathy Fennick.

Your line is now open.

Kathy Fennick: Hi, this is Kathy Fennick with Pyramid Healthcare Solutions. My question is regarding the updates to ICD-10-PCS. Will that occur annually and at the same time as the ICD-9 or ICD-10, excuse me, CM updates?

Pat Brooks: Yes. We plan to maintain both systems and update them annually. The only issue being discussed now is how big the updates will be because of that potential freeze where we would just restrict the movements for a few years to just new technology and new diagnoses. But after ICD-10 is implemented, as I said on one of the slides, beginning October 1st, 2014, there'll be regular updates to both coding systems, ICD-10-CM and ICD-10-PCS. And those who will flow in the future, just like the update timing for ICD-9-CM now. In other words, you would know about this during the summer, you would implement the code changes by October 1st just like you do with ICD-9 now.

So we're phasing in to that where we'll replace the 9 with 10 and where we'll annually maintain and post those updates on our web pages.

Kathy Fennick: Great. Thank you.

Operator: You next question comes from the line of Thravy Berma.

Your line is now open.

Thravy Berma: Hi. I work with the practice of Dr. Anita Berma, and we are a one-physician practice. And what I wanted to find out is we use an intermediary clearinghouse to send our claims to you all. So, other than changing – actually changing our codes from ICD-9 to ICD-10, it's an internal medicine practice and we basically do just E&M codes – so other than changing, do I have to do anything else in my software to make it compliant to yours because the clearinghouse said they would take care of whatever they need to at their end?

Chris Stahlecker: I guess that's a question back to you. How do you deliver your claims to the clearinghouse?

Thravy Berma: We deliver them like – well, I code them. I do the coding in the office and we send them electronically to the clearinghouse and (inaudible).

Chris Stahlecker: The clearinghouse may or may not have a format change for you. The clearinghouse is performing the conversion from 4010 to 5010 on your behalf. That should be no incremental work for you there, but they may need additional content from you and, therefore, they may have changes to the format that you are sending the files to them. They are kind of acting as your business associate.

Thravy Berma: OK. OK. So, I sort of – other than whatever they require us to do in order to be compliant, there's nothing else that we need to do at our end?

Chris Stahlecker: That's correct. That's why we encourage you to contact them early to see if there is a change for you.

Thravy Berma: OK. Great. Thank you.

Chris Stahlecker: Yes.

Operator: Your next question comes from the line of Doris Hayne.

Your line is now open.

Pat Brooks: Hello, Doris?

Doris Hayne: Hi. I am so sorry. I didn't even know my call went through.

Pat Brooks: It's OK.

Doris Hayne: I have a simple question. We are a small ophthalmology practice. We use the E&M codes. We understand that all of our diagnoses are going to have to change to the new ICD-10 codes. But as far as our doctor's cataract surgery, his visual fields, the diagnostic testing, will those procedure codes have to comply now with the new?

Pat Brooks: If you're billing for his Part B bills, and which you are, you're using CPT codes now, you'll continue to use CPT codes. That will not be impacted at all.

Doris Hayne: OK. All right. Thank you.

Pat Brooks: You're welcome.

Operator: Your next question comes from the line of Ina Bender.

Your line is now open.

Ina Bender: Hi. I'm Ina Bender from Montana Hospital. I have actually two questions. Are there any plans to update or create new Coding Clinics from coding perspective? And the second question is, is Medicare doing any outreach with physician groups to educate physicians on the need to become much more detailed in their reports? Because when you look at the whole ICD-10 documentation requirement for coding purposes, it requires a lot more detail than you would find typically in today's operative reports?

So, is there any outreach to raise that awareness with physicians? Because most hospitals depend on physician documentation and it's always a struggle and a challenge to get physicians to document all the things you need.

Pat Brooks: This is Pat Brooks. We are in discussions with the American Hospital Association on Coding Clinic, and we do understand that they intend to make a switch to convert the coding clinics from ICD-9-CM to ICD 10. I can't give a time line or when they'll make formal announcements about that, but they do intend to transition beyond the ICD-10 time.

And then for the outreach, we have had an outreach call for the physician specialty groups already, and you can look at that on our website where we're talking about. And we had AAPC and AHIMA on the phone and CDC with us to encourage good documentation. We'd like to have good documentation now for ICD-9, and we'd like to have it for ICD-10. So, yes, that was part of that outreach effort and we did encourage each specialty group to share those slides or modify them as they needed with their own groups.

And I imagine we're going to be continuing to have these kinds of outreach calls to focus on various parts of provider groups. And we certainly will consider what you said about continuing to encourage better documentation.

Ina Bender: It'll be appreciated. Thank you.

Pat Brooks: Thank you.

Operator: Your next question comes from the line of Dawn McKenna.

Your line is now open.

Dawn McKenna: Yes. Hi, this is Dawn McKenna. And my question is in regards to the call. On slide 41, it states on 5/26, there was a call for the professional claim, and I am unable, under the Downloads, to retrieve that. Is that still in the works to be brought there or should I be going someplace else to retrieve that information?

Pat Brooks: Well, what year was that? You would have to click on the year when the call was held.

Dawn McKenna: It was this week – this year, ma'am.

Chris Stahlecker: Are you talking about the 837 Professional presentation? Are you talking about the billing presentation? You are on slide 41.

Dawn McKenna: Here on slide 41, the 5/26 professional claim?

Chris Stahlecker: The 5/26, yes, that's the 837 Professional claims. I'm advised that the slides are present but the transcripts are not.

Dawn McKenna: OK.

Chris Stahlecker: We're just pending delivery and review for those transcripts to be posted, but they will be.

Dawn McKenna: OK, fabulous. Thank you.

Chris Stahlecker: OK, and that may be where the prior questions from Jeff should be directed. And so go and have a look at those transcripts and – and/or call in on June 30th date for it and you could ask a question then about those allowed amounts. Thanks.

Operator: You're next question comes from a line of Stephanie Matsuda.

Your line is now open.

Stephanie Matsuda: Hi. I'm Stephanie from MedComm Soft. My question was with the transition to the ICD-9 to the ICD-10. Will there be a new HCFA form to accommodate that?

Pat Brooks: Are you talking about billing forms? And Chris covered that, if she wants to go over that again.

Chris Stahlecker: Those paper forms are not expected to change at this time for any expansion for the diagnosis codes. There's already enough room. And there will be an indicator in advance of the diagnosis code itself to indicate if it‘s a zero. A zero would mean the ICD-10 code value and a nine would mean the ICD-9 code value.

Stephanie Matsuda: OK, great. Thank you.

Female: Sure.

Operator: You're next question comes from the line of Diana Seymour. Your line is now open.

Diana Seymour: Yes. This is Diana Seymour from the Blue Cross Blue Shield of Arizona. We have a quick question on the COBC crossover files during the transition period where we'll be ready for 5010, but yet your providers may still be sending you 4010 files. On those files that we get – will we be getting a 4010 and a 5010 file?

Chris Stahlecker: Well, you are able to if you are currently a receiver of crossover claims, you can begin testing. I think the testing is scheduled to start sometime in July. So, you can test early for that, and you can get a 5010 version of your production 4010 claims, in test mode.

Then once we are into production, if a provider is billing the 5010 format yet a payer is not able to take that in, we have a process to accommodate this situation. First, shame on them because they should be ready on January 1st, 2011. But if they're not ready, such as someone pointed out a Medicaid may not be ready, we have a process where, for example, if the claim came in on paper, it's data content would not be rich enough to be put into an 837 format, so we will create what we call an 837 skinny. The 837 skinny does contain all of the required content to be a compliant 837 claim, even if some of the data elements need to be populated off of Medicare Fee-For-Service reference files, internal files, So, let me restate it again because I gave you a lot of information. If a payer was on 4010 and a provider submitted a 5010 claim, the skinny COBC claim would be sent to that trading partner. So, it's not as rich as an electronically submitted 4010 claim but it will be a compliant crossover claim.

Diana Seymour: If the trading partner was up and ready with you on 5010 but the claim you process from the provider was 4010, are you going to output that crossover file to us in 4010 or in 5010?

Chris Stahlecker: When the trading partner says they want to get 5010, they will get 5010.

Diana Seymour: So, you will be upcoding those claims?

Chris Stahlecker: We're not creating data, but all of the necessary data content will be available.

Diana Seymour: So they are skinny 5010?

Chris Stahlecker: If specific data elements fall into that category, yes.

Diana Seymour: Thank you.

Hazeline Roulac: Hello, Christopher, this is Hazeline. We have time for two more questions.

Operator: Two more questions, not a problem. Your first question comes from the line of Donna Bellmore.

Your line is now open.

Donna Bellmore: Hi. This is Donna Bellmore, Northwinds Psychiatric. I know that you covered this topic a couple of times with a couple of different scenarios, but what I'm wondering is that 5010 time line that starts January 1st, 2011, and hopefully all of my payers are going to be able to accept those claims at that point in time. The secondaries, I understand, you're going to take care of them for me.

Those primaries, since I'm converting over to the 5010, what do the primaries not have any kind of a time line that they absolutely have to have this ability to take these claims?

Chris Stahlecker: Well, according to rule, they are to be engaged in testing during the calendar year 2011 and cut over completely by January 1st, 2012. So, they have the same…

Donna Bellmore: So, really until January 1, 2012. It's going to be hit or miss for a provider to bill it under a 5010.

Chris Stahlecker: It would be wise for you to do an outreach to the key payers that you send your claims to, to find out what their time line will be to accept your 5010 test transactions.

Donna Bellmore: OK. That's good. All right. Thank you.

Operator: And your final question comes from the line of Diana Enriquez.

Your line is now open.

Diana Enriquez: Hi, this is Diana, and I'm calling from Hospice of El Paso in El Paso, Texas. And what we want to know how it's going to affect our hospice services. We

don't really fall under the inpatient hospice or outpatient facilities. How is it going to affect us?

Pat Brooks: Are you asking from a coding perspective or as systems perspective?

Diana Enriquez: Well, both.

Pat Brooks: Well, from a coding perspective, I'll take that first. If you submit ICD-9 diagnosis codes now, then you will replace those with ICD-10-CM diagnosis codes for services provided on or after October 1st, 2013.

Now, I'll turn to Chris for the systems part.

Chris Stahlecker: And if you're submitting claims electronically to your Home Health Intermediary, then you would need to upgrade your file, format from the 4010 format to the 5010 format.

Diana Enriquez: OK. Thank you.

Conclusion

Hazeline Roulac: OK. Thank you everyone. Unfortunately, we've run out of time for today. We're not able to take anymore question. We do apologize to everyone that remains in the queue that we were not able to get to you today.

We think that this has been a really great call, very informative, with some wonderful questions. And we really do appreciate your participation in the ICD-10 Implementation in a 5010 Environment conference call.

As a reminder, the written and audio transcript of today's call will be posted to the CMS ICD-10 web page at www.cms.gov/icd10. The audio transcript should be available in approximately two weeks and the written will follow thereafter.

Also, please mark your calendar for Monday, September the 13th, from 12 noon until 1:30 Eastern Time for the next ICD-10 call.

And we want to thank our speakers, Pat Brooks and Christine Stahlecker. We appreciate you taking your time to be with us today.

And we hope everyone has a great day. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

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