

Centers for Medicare & Medicaid Services
ICD-10-CM/PCS National Provider Call for Physicians
Moderator: Ann Palmer
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12:30 pm ET

Operator: Good morning, my name's Ken and I'll be your conference operator today. At this time I would like to welcome everyone to the ICD-10-CM/PCS National Provider Call for Physicians. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you'd like to ask a question during this time, simply press star and the number one on your telephone keypad. If you'd like to withdraw your question, you may press the pound key. And now I'd like turn the call over to Ms. Ann Palmer. Ma'am, go ahead.

Ann Palmer: Thank you. Hello, my name is Ann Palmer and I'll be moderating today's ICD-10-CM/PCS conference call for physicians and providers who missed the two previous conference calls. Please note this call is being recorded and will be transcribed. The call transcript will be posted shortly after this call. You can find transcripts and other conference call information by selecting CMS Sponsored Calls on the left side of the ICD-10 Web page located at www.cms.hhs.gov/ICD10.

CMS will not be offering Continuing Education Units for this conference call. Sue Bowman will discuss the American Health Information Management Association CEUs later during her presentation.

Speakers from the four ICD-9-CM Cooperating Parties, which represent a long-standing public and private sector partnership between the Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, American Hospital Association, and American Health Information

Management Association, will be presenting today. Two practicing physicians will also be part of our discussion.

A PowerPoint has been developed and posted on the ICD-10-CM Sponsored Calls Web page for participants to follow along with the presentation. You can access this by selecting CMS Sponsored Calls - on the left-hand side of the CMS Sponsored Calls page - which is available from the ICD-10 page. The PowerPoint presentation is in the Downloads section and is called "ICD-10 Overview Presentation."

Our first speaker today is Pat Brooks who is Senior Technical Advisor at CMS. Pat is going to provide information about ICD-9-CM, why a new coding system is needed and what characteristics are needed in it, reimbursement and quality problems with ICD-9-CM, and benefits of adopting the new coding system.

Pat Brooks: Thank you, Ann. Currently ICD-9-CM is the national HIPAA standard used in this country. The CMS issued a proposed rule on August 22, 2008 in which we proposed replacing ICD-9-CM with ICD-10 as the national HIPAA standard. And in this proposed rule we proposed an implementation date of October 1, 2011. The comment period is now closed and we are, at this point, evaluating those comments. We do not have any final decision about when or if ICD-10 will be implemented.

All this information would be included in any final rule. And at this point, we do not have a definitive date of when we would issue a final rule. However, you can read the proposed rule on slide 66 in today's handout. And at which time our final rule is issued, we will provide links at that same site - on slide 66 - to read any final rule on ICD-10.

I will now proceed with discussing a brief history of ICD-9-CM. The World Health Organization, or WHO, developed ICD-9 for use worldwide. Since that did not have enough detail for the United States, we in the United States developed a clinical modification prior to implementing ICD-9. We refer to this clinical modification as ICD-9-CM, with the CM standing for clinical modification. We implemented ICD-9 in 1979 in the United States. We basically expanded the number of diagnoses that were present in this coding system.

The World Health Organization did not develop a procedure code system to go along with their ICD-9 diagnosis system. So the U.S. did develop a procedure coding system, and this is the procedure part of ICD-9-CM. For the many physician offices listening today, you know that you don't use ICD-9-CM procedures - the only part of ICD-9 that you use is the diagnosis part.

On slide 4, we talk again about the users of ICD-9. Once again, the most important issue is that ICD-9 diagnosis are used by all types of providers in all types of settings. So in a physician's office, you would use ICD diagnosis. These diagnosis codes are also used in hospitals - both inpatient and outpatient - ambulatory care centers, home health, and any other settings that report ICD-9 diagnosis codes. The replacement being proposed to replace ICD-9-CM is the ICD-10-CM - the diagnosis part.

The next part of ICD-9 is the procedures section, or Volume 3. It's frequently referred to as ICD-9-CM. These procedure codes are only used by inpatient hospitals. Therefore, in the proposed rule, we propose replacing ICD-9-CM procedures with ICD-10-PCS, or procedure coding system.

The third point is that CPT, or Current Procedural Terminology, is used by all ambulatory and physician procedure reporting and, also, alphanumeric

HCPCS are used in these settings. The proposed rule does not propose to change the reporting practices of the use of CPT or HCPCS - those would continue being used even if ICD-10 is being implemented. So, therefore, physicians' offices - if ICD-10 is implemented - would stop reporting ICD-9 diagnosis and begin reporting ICD-10-CM diagnosis. And would continue to report CPT and HCPCS codes.

Slide 5 talks about what ICD-9-CM is used for. One important thing it's used for on the inpatient side is to calculate payment. For inpatient Medicare hospital reimbursement, we use the Medicare Severity Diagnosis Related Groups or MS-DRGs. ICD-9-CM is also used to implement coverage decisions.

So for the various settings, if something is to be covered, sometimes there'll be a list of specific diagnosis codes for which the service is covered. Or - on the contrary side - perhaps for certain procedures there might be a list of diagnoses that are not covered. In this case, we implement these coverage decisions by the use of ICD-9-CM diagnosis codes. We also use ICD-9-CM to compile statistics. Our national healthcare data is ICD-9-CM diagnosis based. We also use it - for - to assess quality of care.

Slide 6 discusses the fact that ICD-9-CM is quite outdated. It's 30 years old, and much technology has changed since then, and medical practice has changed. Historically, the ICD system was updated approximately every ten years. So for this particular version of ICD, the Tenth revision, we are close to three times the average amount of time between the updates. As a result, as we've tried to maintain ICD-9-CM by adding in new diagnosis codes and procedure codes, many categories have become full. And it's been quite difficult to add new codes. This has been a particular problem on the procedure side, but it's also an issue on the diagnosis side. We also find that

the ICD-9-CM codes are not quite descriptive enough. They don't tell us enough detail about what's done to the patient and about the conditions the patient has.

On slide 7, we discuss the question of why we need a new coding system. Well, there two main issues. First, since - as we've already discussed - ICD-9-CM is used for reimbursement, then it's important to have accurate payment for services based on accurate and precise ICD codes. It's also important to have accurate codes to measure quality and to look at outcomes.

Slide 8 shows that we also need to have a coding system that's flexible enough to quickly incorporate emerging diagnoses and procedures. In other words, it needs to be able to be expanded and updated with advances in medical technology or medical science to capture new diagnoses or clarify them better and to add in new procedures. It also needs to be exact enough to clearly identify diagnoses and procedures. Unfortunately, ICD-9-CM - since it is 30 years old - is neither of these. It's not flexible, and it's not exact enough to identify the diagnoses and procedures.

Slide 9 gives an example of a reimbursement and quality problem with the diagnosis part of ICD-9-CM. In this example, a patient has a fracture of the wrist and fractures the left wrist. A month later, the patient comes in with a fracture of the right wrist. The ICD-9-CM diagnosis codes do not currently identify left versus right for wrist fractures or for any other part of the body. Additional documentation is required to show the location. ICD-10-CM, on the other hand, the diagnosis codes are much more descriptive. They give information on whether it's left versus right. And they also give other important information such as whether this is an initial encounter or a subsequent encounter. It also provides information on whether there's routine

healing, delayed healing, nonunion, or malunion. So one can look at the codes in the data and discover the progress of the patient and look at outcomes.

Slide 10 is an example that will be used for a hospital inpatient and that uses ICD-9 procedure codes. And this example, we just mention a combination defibrillator pacemaker device. When the codes for this new kind of device were created, there was not room to assign it in the cardiovascular chapter of ICD-9-CM where all the other defibrillator and pacemaker procedure codes are assigned.

Coders and researchers have trouble finding it because we had to put it in the front of the book in a previously unassigned chapter. At this point, that first chapter with the hundred codes is now full, and we've moved to a second overflow chapter that's in Chapter 17 of the book. And more than likely, we will fill up this additional chapter of unassigned codes this year. As of that point - for hospital inpatient procedures - we will have to begin assigning chapters for orthopedics, cardiovascular, and other procedures, more than likely, to chapters of the eye and perhaps to the ear. This is a problem that will help degenerate our ability to find and track medical care in the inpatient setting.

ICD-10-PCS provides much more distinct codes for these types of devices, and they are in an orderly process. And it's also easy to expand these codes so that we won't be faced with a degeneration of structure that we have now with ICD-9-CM procedures.

On slide 11, we discuss the benefits of adopting a new coding system. And, as stated previously, we are proposing ICD-10-CM for diagnosis and ICD-10-PCS for procedure coding in the inpatient setting. The new coding system incorporates much greater specificity, details, and clinical information. And it

would result in an improved ability to measure healthcare services. It also has increased sensitivity when refining grouping and reimbursement methodology. For instance - MS-DRGs - we would be able to look at long-term data once we have ICD-10 and decide if we needed to do additional refinement in the MS-DRGs.

The improved coding system of ICD-10 would also enhance our ability to conduct public health surveillances. We will more clearly be able to diagnose and track patients with certain diseases. There would also be a decreased need to include supporting documentation with claims - as people have to send in additional documentation to describe what's wrong with the patient.

Today we have four organizations represented on the call. We are called the Cooperating Parties for ICD-9-CM. This group was basically established back in the 60s through a formal agreement with the Department of Health and Human Services predecessor organization. At that point, the American Hospital Association was named as the lead clearinghouse for ICD-9-CM. And it was decided that they would work closely with others in this group to maintain ICD-9, and to update, and respond to questions. The four organizations are:

- CMS – And I am Pat Brooks; I am the representative for CMS.
- Donna Pickett from CDC – And Donna Pickett, also, in addition to being the lead of diagnosis part of ICD is also the representative to the World Health Organization. I should also mention that CMS - since the World Health Organization did not develop a procedure volume to go with ICD-10 - we led the effort to develop a procedure coding system to go with ICD-10 and that's called ICD-10-PCS, or procedure coding system. And I'll be discussing that in some greater detail later.

Donna Pickett, agency CDC, has the lead to the World Health Organization and worked on the international version of ICD-10. She also led the efforts in the U.S. to develop a clinical modification of ICD-10 or ICD-10-CM.

- Nelly Leon-Chisen represents the American Hospital Association and she will be discussing in detail the role of the AHA in ICD-9 and their future role with ICD-10.
- Sue Bowman represents American Health Information Management Association, or AHIMA, and she will discuss their roles in implementation.

These four Cooperating Parties are responsible for not only for maintaining and updating the ICD with 9 and 10 - they are also responsible jointly for developing the official coding guidelines that go along with ICD-9-CM.

We will also have two physicians who will give their views on the implementation of ICD-10. And these two physicians have been heavily involved in work with ICD-9 and have participated in efforts with the Coding Clinic for ICD-9-CM.

This morning - this afternoon - Donna Pickett from CDC was to present ICD-10-CM but, unfortunately, she was called away and is not able to make her presentation that she made to the three other calls. I'll be going over those for her. But she is the Medical Systems Administrator for CDC, and the part of CDC she works in is the National Center for Health Statistics and the Classification of Public Health Data Standards. You'll see her e-mail below. Should you have future questions about the development of ICD-10-CM, or on ICD-9-CM diagnosis issues, if you were interested in requesting a new or revised code - Donna Pickett does have a lead on that issue.

Turning to slide 14, we will discuss the development of the international version of ICD-10. In 1990, the ICD-10 was completed and endorsed by the World Health Assembly. Once again, I should mention this is the diagnosis only part. The World Health Organization did not create a procedure coding system. We in the U.S. developed our own separately. In 1994, WHO released the full ICD-10 for use worldwide. And in October 2002, as of that date, ICD-10 was published in 42 languages and that includes the six official WHO languages.

It has been implemented in 138 countries for mortality, or cause of death, and 99 countries for morbidity - much as we code for the injuries and diseases of a patient. While we have not in the U.S. adopted ICD-10, we have begun reporting ICD-10 for cause of death reporting. And in January 1, 1999, the U.S. did begin reporting on death certificates using ICD-10.

Slide 5 lists the many countries that are already using ICD-10 for a variety of purposes. And this list includes - some of them are using them for reimbursement and others are using ICD-10 for case mix analysis - looking at the severity of patients and making decisions like that. And you'll see that they range from the United Kingdom, implementing ICD-10 in 1995, up to Canada, implementing ICD-10 in 2001. I should also mention that Australia has been quite active - in 1998, implementing their own clinical modification of their ICD-10.

Slide 16 discusses the development of the clinical modification that we use in the United States. Once again, this effort was led by CDC. The CM stands for clinical modification. CDC consulted with a number of groups in developing the clinical modification.

The previous drafts were posted on CDC's website and CDC actively encouraged the review by certain physician specialty groups of their own chapters of ICD to make sure that these diagnoses represented the way physicians diagnose in the United States.

CDC also received input from a number of clinical coders who looked through the previous version and made suggestions about how the clinical modifications would work best for people in this country. And other users of ICD-9-CM also gave input to CDC.

In addition to getting all this input, CDC went through previous minutes of the ICD-9 Coordination and Maintenance Committee, which updates ICD-9-CM. And they looked at recommendations or requests from specialty societies that could not be incorporated into the ICD-9-CM because there just was space limitations. And as a result of moving to ICD- 10, they tried their best to bring many of these requested changes to make sure that they were captured in ICD-10-CM. ICD-10-CM is not used in the United States at this time.

Slide 17 and slide 18 show a partial list of those reviewers that actively worked with CDC in developing the clinical modification of ICD-10. And these include groups such as American Academy of Dermatology, Neurology, and on through the American Academy of Orthopedic Surgery. The next page gives a few more of these reviewers that worked with CDC on their particular sets of codes within the coding system such as the American Burn Association, the American Diabetes Association, the American Nursing Association. And the American Psychiatric Association was particularly involved - making sure that their version of DSM worked well with our ICD-10-CM.

And I understand from CDC that there's a new version of a DSM that's under development now, and the American Psychiatric Association is working very closely with CDC to make sure that the codes included the most recent version of DSM will be included in ICD-10-CM. We'll also point out that Workman's Compensation made a request for codes in the clinical modification so that they can better capture workplace injury.

Slide 19 talks about some major modifications based - made to - ICD-10-CM. And I'll go over these. The first is that there were added the trimester codes to the obstetric codes so that the fifth digits from ICD-9-CM will no longer have to be used. Also, CDC reports that the ICD-10-CM has revised the diabetes codes. And that the fifth digit for the diabetes codes will no longer be used. They also expanded the codes used to capture injuries and the diabetes codes. And added code extensions for injuries and external cause of injury. In other words, the clinical modification for injuries and external cause of injuries is longer and more detailed than what's in the international ICD-10 version.

Slide 20 illustrates laterality that's present in ICD-10, and I mentioned that earlier on my example of the fractured wrist. This shows also how you can identify this type of information for malignant neoplasm of the breast. This code - C50.111 - is Malignant neoplasm of the central portion of the right female breast. The C50.112 indicates a Malignant neoplasm of the central portion of the left female breast. This type of detailed information is great for longitudinal studies or to look at national healthcare information.

Slide 21 lists some more benefits of enhancements made. One I've already mentioned was that DSM IV - CDC worked very closely with American Psychiatric Association to make sure that DSM IV and ICD-10-CM are compatible, and they're doing the same thing for DSM V. Chapter 2, which covers the neoplasm and morphology codes corresponds to the ICD-0-2,

which has been used by the Cancer Registry Program since 1995. In addition, the nursing classification system - ICD-10-CM is compatible with about 99 - about 95 percent - of those.

We'll move to slide 22 where we'll discuss some structural differences between the ICD-9-CM diagnosis codes and then later the ICD-10-CM codes. As many of you know, ICD-9-CM has - is - three to five digits long. Most of the codes - those in Chapters 1 through 17 - are all numeric. They are all numbers. There are two supplemental chapters where the first digit is an alpha character - and that's the E code chapters, External Cause of Injuries, and the V code chapters. All the rest of these are numeric in the E and V codes. And we give examples below. Here's a three digit code - 496, commonly known as the code for COPD, the Chronic airway obstruction not elsewhere classified. We have a four digit code, 511.9, Unspecified pleural effusion. And we have a five digit code from the V code chapter, V02.61, Hepatitis B carrier. So you see the difference in the current ICD-9 codes.

Slide 23 shows the structural makeup of ICD-10-CM codes. ICD-10-CM will run from three to seven digits. The first digit is always going to be an alpha character - A through Z - and it's not case sensitive. It doesn't have to be a capital or small letter - either works. Digit two will always be numeric. Digit three of the ICD-10-CM codes is alphanumeric or numeric, so that digit three can be either. Digits four through seven are alpha or numeric and, once again, the alpha characters do not have to be - are not - case sensitive.

We give you four examples to show - the four - below you see how the first digit is an alpha character for all of those, the second numeric, and the third character. We have examples of some that are numeric, others that are alpha. And you'll notice that the bottom example has an alpha character in the

seventh digit. You'll notice the decimal point after the first three digits. And we have examples for various things there for you to look at.

Slide 24 - actually will be a great improvement for many people who use the ICD-10-CM. Currently, if one, say, wants to use code 143.0 and you turn to this code in the book - in the ICD-9-CM book - you'll see the word Upper gum. And you're really not clear by looking at those two words exactly what's meant. You have to go back to the category heading of the 143 for the Malignant neoplasm of the gum to understand that we're talking about Malignant neoplasm of the upper gum when you're talking about 143.0. ICD-10-CM has full code titles beside each code number. So you see for C03.0 - it's expressed in full as Malignant neoplasm of upper gum. I believe that this will be viewed very favorably by most people who use the coding system now.

Slide 25 is some references for you on CDC and I strongly encourage you to go and look at this information - general information on ICD-10. On list it's the first bullet under 25. You can go and just find out all about ICD-10 on this web page. You will also see - the second one mentioned - there's some ICD-10-CM files. And what these files are - if you want to look at an ICD-10-CM book - we have an electronic file of the index and the tabular part of ICD-10 right now on the website. So for instance, if you were curious about what diabetes mellitus would look like on that part of the code book, you could either open up the index file, follow the index to get the series of codes in the tabular book. Or you could open up the tabular book and do a search on diabetes and get that range of codes. And just browse for yourself to see what the codes look like.

There's also a couple of tools there. We have something called the general equivalency mappings on this website. And what these are - they're like

crosswalks - they take the ICD-9-CM code, for instance, diabetes, and tell you what code or codes it would map to in ICD-10-CM. We do this by directional mapping. We map from the ICD-9 diagnosis codes to the ICD-10-CM diagnosis codes and we map back from each ICD-10-CM code back to ICD-9. Before you look at those maps, I would strongly advise you to look at the General Equivalency Mappings Guideline book that explains how the guidelines are developed and how to use them.

Also on that web page are the official coding guidelines for ICD 10 - we've published them. These official coding guidelines are being updated now as are the ICD-10-CM tabular and index files. And CDC will post new mapping guides and ICD-10-CM files at the end of December for the 2009 version of this coding system. Once again, I would encourage you to open and browse through that to see what it looks like. There are even some paper code books on the market now - if you would prefer. You can get a book like that, and look at it, and see how you feel this will be to learn, and what's its all about.

I'll move on to slide 26 now, and cover the ICD-10 procedure coding system. As I stated before, CMS has the lead on the development of ICD-10-PCS and on its maintenance. The ICD-10-PCS will only be used in inpatient acute hospitals. It will not replace CPT or HCPCS in any other setting. So for those physician offices on the phone today, I'll go through and describe ICD-10-PCS but you won't be using this in your physician offices. The ICD-10-PCS - the PCS stands for procedure coding system.

WHO did not develop a procedure coding system and so we needed to do that ourselves in the U.S. to have an inpatient coding system to accompany ICD-10. It was first released in 1998 by CMS, and we have updated it annually since that time. We discussed this coding system and ICD-10-CM regularly in our ICD-9-CM Coordination and Maintenance Committee meetings. And we

asked the public for input with any suggested updates for revision each year and then make annual revisions. ICD-10-PCS is not in use at this time.

Slide 28 shows the structural differences between ICD-9-CM, and I'll point out the 10-PCS later. ICD-9-CM has only three to four digits. One could see with such a small number of digits why you couldn't go into great detail and capture great numbers of procedures. All four of the digits in ICD-9-CM procedures are numeric. And I gave you two examples - one of a three digit ICD-9 procedure code and one of a four digit procedure code.

Turning to slide 29 - ICD-10-PCS looks quite different. ICD-10-PCS has seven digits in every code. Each of these digits can be either alpha or numeric, and the alpha characters are not case sensitive. Numbers 0 through 9 are used, but we decided not to use the letters O or I because we wanted to avoid confusion with the numbers 0 and 1. Examples of two of these ICD-10-PCS procedure codes involving Excision of the liver and Repair of the esophagus with an autograft are shown below and you'll notice the mix of numbers and letters in these codes.

The other thing for those who work in an inpatient setting - you'll notice how precise we can get in describing the approach used, with the ability to put more information into a single code. I'll illustrate that on slide 30. Currently, hospitals report an angioplasty code of 39.50. There are 1,170 ICD-10-PCS angioplasty codes. And the reason there are so many is these codes actually tell the vessels - the artery - that the angioplasty was performed on. Where the current one, you can't tell what part of the body this procedure is performed on.

You can tell the approach used in doing the angioplasty - whether it was open, percutaneous. You can also tell the device that's inserted - if one is - such as

was a drug-eluting stent used, or a regular stent, or was no device used. All of that information is captured within one code. Hospitals currently have to report multiple codes to get at this same bit of information. So one code gives much more detail.

Slide 31 discusses the advantages of ICD-10-PCS. As we've just shown, it provides much greater detail on the procedures performed. It is also able to capture more information on new technologies and devices. We are having an extremely hard time updating ICD-9-CM to capture new technology because of the constrained limitations of space.

ICD-10-PCS also has a logical structure with clear, consistent definitions. For those of you on the phone who work in the inpatient hospital side and want to look up these definitions, we define each term clearly in ICD-10-PCS. The definitions don't vary by chapter as currently ICD-9-CM procedure codes do.

Slide 32 shows information that we have available on ICD-10-PCS. We have the complete version of ICD-10-PCS - the 2008 version - on our website. You can find the index, and the tabular, and the list of full code titles. There's also a User Guide that includes the official coding guidelines that explains how to use ICD-10-PCS, and clearly describes the definitions of the terms used, and how codes are built.

As we have general equivalency mappings for the ICD-10-CM diagnosis, we also have these mappings for ICD-10-PCS. We take each ICD-9-CM procedure code and map it to the code or codes down in ICD-10-PCS. And it's bi-directional because we have a separate list of mappings that take each ICD-10-PCS code and take it back to the appropriate ICD-9-CM codes. We have updated PowerPoint speaker slides for those if you want to look at them and maybe give a presentation in your facility. And we have a technical paper

explaining the use of ICD-10-PCS. And I give you the website to find all this information. By the end of December 2008, we will publish updates of all these files for the 2009 version of ICD-10-PCS.

Slide 33 discusses an interesting process that we undertook recently where we decided to take these mappings and see how well they work in converting payment systems to ICD-10. What we did is - we decided to convert the MS-DRGs, which are now based on ICD-9 codes, and we wanted to begin converting them to ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes. We selected the digestive system part of the MS-DRGs to begin with and we had our contractor go through, use these mappings, and convert that one part of MS-DRGs to see how well the mappings worked. And they worked very well.

We've presented the results of this activity at the September 24 through 25, 2008 ICD-9-CM Coordination and Maintenance Committee Meeting. I would encourage any of you who are interested in that to look at our website on slide 66. And read the summary report of this meeting and read the detailed slides we gave for the use of the general equivalency mappings converting the payment system.

We were able to convert automatically, with a search and replace program, 95 percent of the codes in MS-DRG without having to go through and do - I'll call it manual review - looking at medically and clinically. We planned to take what we've learned from this process and convert the rest of the MS-DRGs using the mappings by October 1, 2009. Obviously, this is just an exercise to see how well the mappings work. It's not a final rule on the - of the - ICD-10 version of MS-DRGs. Any ICD-10 version of the MS-DRGs would go through formal rulemaking.

We hope, though, by doing this exercise and sharing it with everyone that - people in hospitals, vendors, providers who have data, their programs and policies they want to convert - they can learn the best way to convert this data from ICD-9-CM to ICD-10, taking what we've done and learning from it.

By the end of December 2008, we will have the results of the conversion of the digestive system part of the MS-DRGs to ICD-10, and we are gonna post that on our website along with the updated ICD-10-PCS file. And that's all, Ann.

Ann Palmer: Thank you, Pat. Nelly Leon-Chisen, who is the Director, Coding and Classification, at the American Hospital Association, is now going to discuss AHA's roles, plans, and implementation issues regarding ICD-10.

Nelly Leon-Chisen: Thank you, Ann. And we're now on slide number 35. As has already been mentioned, the American Hospital Association has been involved with ICD-9-CM for quite a number of years. And AHA is one of the Cooperating Parties. So I'll talk about the Central Office on ICD-9-CM, our role in providing coding education today through our publications, our audioseminar series, and speaker's bureau. And then share information regarding our thoughts and plans for ICD-10-CM and 10-PCS education and implementation.

On slide 36, we have a little bit of information about the AHA Central Office on ICD-9-CM. This office was created in 1963 through a Memorandum of Understanding with the Department of Health and Human Services. The office is housed and supported by the AHA, and it serves as a clearinghouse for issues related to the use of ICD-9-CM. We receive coding questions from all types of users and we provide direct responses free of charge.

The questions can range from simple questions related to locating a fifth digit to more complex questions for new conditions or new technology where the classification does not readily provide guidance. The goal of the office, then, is to maintain the integrity of the classification system so that the codes can be applied in a uniform and consistent manner by all users.

Moving on to slide 37 - because we get hundreds of letters every month, we quickly become aware of any shortcomings, or problems, or limitations of the coding system. The letters that we get can become recommendations for revisions and modifications to the current ICD-9-CM, especially after we bring those issues to the Coding Clinic Editorial Advisory Board and we're not able find a good match with the existing codes.

We also developed educational materials and programs on ICD-9-CM including audioseminars on hot topics, but our best known resource is the AHA Coding Clinic for ICD-9-CM.

Moving on to slide 38 - Coding Clinic has been in continuous publication since 1984. It is a quarterly newsletter devoted strictly to ICD-9-CM coding. It consists of an Ask the Editor section, which has the frequently asked questions received by our office or questions that have never been addressed and that, therefore, need wider dissemination.

These are real-world questions received through our clearinghouse service, and I'm sure that many of our listeners on today's call have sent us a question from the past. And you may have also seen some of those questions and answers published in Coding Clinic. Periodically, we also provide more extensive educational articles related to the coding of more difficult scenarios. Some recent examples that some of you may be familiar with are respiratory failure and sepsis.

Then our fourth quarter issue is typically the largest issue of the year, and this contains the ICD-9-CM code updates that come in every October. And we provide additional clinical information to help educate our coders on the new codes as well as examples on how to apply these new codes.

Starting with the third quarter issue of this year, we have introduced a new section on the reporting of Present on Admission, or POA, indicators as we work with CMS to develop a process for handling those questions through our existing ICD-9-CM process.

The Coding Clinic publication is supported by the Cooperating Parties and the Editorial Advisory Board so that the content of every issue is approved by these groups before we can publish. The Editorial Advisory Board, or EAB, includes representation from physician groups like the American Medical Association, the American Academy of Pediatrics, the American College of Surgeons, and the American College of Physicians. In addition, we consult with different specialty groups on an as-needed basis when we get questions that we're not able to address through our EAB. We also have coding representatives who are currently employed by providers.

On slides 39 and 40, we list the major functions of Coding Clinic. These include providing official ICD-9-CM coding advice because you can rely that every question and answer has been discussed and approved by the Cooperating Parties and the EAB. And we also republish the official guidelines and any changes to those guidelines. We answer questions on code assignment and also address issues of sequencing of codes which may impact on the information that is submitted, especially if we're looking at the selection of principal diagnosis.

We serve as the current reference on regulatory and other requirements for reporting diagnostic and procedural information from medical records. And over time, you have seen issues describing what documentation may be used for coding like - for example - documentation from different types of providers.

We present topics and articles that provide practical information. These topics are generated from the requests for coding advice that come into our office. The goal is to improve the technical coding skills of ICD-9-CM users and, as such, we address issues facing ICD-9 users on data reporting requirements or problems with data edits. So, for example, we deal with situations where there may be problems with a combination of codes, whether it is possible to use two codes together or not, the type of record documentation, and other ICD-9-CM related matters.

On slide 41, let's talk about the Faye Brown's ICD-9-CM Coding Handbook. We believe the AHA's ICD-9-CM Coding Handbook may be the first ICD-9 code training book that was published in the United States and that was back in 1979. It was developed by Mary Converse, who was the founder of the AHA Central Office. It's a textbook used in many coding in HIM, or Health Information Management, programs around the country and it's now annually revised by the AHA Central Office staff.

On slide 42, we start talking about what we have done so far in ICD-10 and what we envision our role to be in the future. Because we believe ICD-10 to be extremely important to our members and their future, we have been actively involved in ICD-10 over the last 20 years and intend to continue to do so into the future.

We have participated in the development of ICD-10-CM and ICD-10-PCS through the Technical Advisory Groups and provided extensive review over the years, both of the codes, the classification as proposed, as well coding guidelines.

AHA members, as well as the AHA Central Office staff, participated in real world testing of both ICD-10-CM as well as ICD-10-PCS. You'll hear more details on the joint AHA/AHIMA-led ICD-10-CM field testing from Sue Bowman in a few minutes. I'd like to add that, as part of the ICD-10-PCS informal testing, we submitted two years of surgical questions referred to the AHA Central Office for coding advice.

These questions required further referrals to the Coding Clinic Editorial Advisory Board because distinct or clear ICD-9-CM procedure codes could not be found. Where the EAB had been required to spend a significant amount of time deliberating over the correct ICD-9-CM code selection, the field testing found that coders were able to easily and accurately assign an ICD-10-PCS code without any problems.

We found the testing overall to have been thorough and representative of the types of medical records that would be coded under ICD-10-CM and 10-PCS. Over the years, we have published articles on ICD-10 and done multiple, multiple presentations on the subject. You will find a few of them on our website. So you may take a look at them and get additional information on the ICD-10. As part of our long-time preparations for ICD-10, since 2004 the Faye Brown Coding Handbook has contained preview chapters on ICD-10-CM and ICD-10-PCS.

These chapters provide an overview, not only of the code structure and how to these codes compare to what we're familiar with in ICD-9-CM, but also

information and checklists on how to start preparing for ICD-10 implementation - whether it would be for an individual such as a health information management professional, or a coding professional, or for an institution - what kinds of things should be considered in terms of personnel training, system issues, or data conversion.

On slide 44 - talks a little bit more about our future plans for ICD-10. So our plans include a Central Office on ICD-10, Coding Clinic for ICD-10, Train the Trainer programs as well as education and outreach for hospitals and others.

We think that the AHA Central Office on ICD-10 would continue to support coding questions through a clearinghouse function in which we would continue to provide direct responses to individual coding questions. And, of course, that information would also be fed through for content into ICD-10 Coding Clinic with the collaboration of the Cooperating Parties. So we envision that the major functions for Coding Clinics for ICD-10 would continue to be similar to what we currently have for the AHA Coding Clinic for ICD-9-CM. And we would continue it in the same format, namely, a hard copy subscription, or an electronic CD, or available through encoder products where many of them - if not all of them - already contain Coding Clinics.

We're now on slide 47. We have already started our educational outreach as far as ICD-10, and more recently we have developed a member advisory that went out to all our hospitals and it's also available through our website. As far as Train the Trainer programs, we believe that there are going to be many different levels of training required. We're ready to help health information management professionals and others as they try to explain and talk through the implementation process, whether it's discussing it with the senior management of their institutions or working with other departments to try to

identify what are the areas that are impacted and how this should go step-by-step working with other departments that would be affected.

We would work with the State hospital associations to try to reach as many hospitals as possible. And the training and education, again, would depend on the role that each individual would play within the facility. Some folks would only need an overview versus more in-depth training for coding professionals, depending on the individual role and the timing would also change. In-depth training of coding professionals would be three to six months prior to implementation to make sure that coding professionals can retain the information when they're ready to apply it. But, general overviews for others that are looking at their information systems, trying to determine the impact, and trying to budget for ICD-10 would be receiving more general overviews earlier in the process.

I would like to emphasize that there needs to be assessment of what is needed. And individuals would need to consider where and how they would purchase their educational resources. We realize - like with so many other new initiatives that providers have had to deal with - there will be many offerings. So we want to make sure that these offerings come from sources that hospitals and other coding professionals have learned to trust over the years.

On slide 48, we have a summary of the major implementation issues that hospitals should look at for this initiative. Obviously, budgeting is something that needs to be considered and it's something that would need to be done over several years because this is a multi-year implementation process that involves different areas.

The areas affected would be personnel training, and, again, that would depend on the role of the individual. Also, you would need to work with your medical

staff to ensure appropriate documentation is available. This is not to say that you need to retrain physicians in order to assign ICD-10-CM or 10-PCS because we have seen through the pilot testing that it is possible to assign codes based on today's documentation. But if we are going to reap the benefits of greater specificity, we need to make sure our medical staff understands what the benefits are of that greater specificity so that we can reduce the number of physician queries required in order for us to assign the right codes.

Also as claims data is increasingly being used for quality reporting and value-based purchasing initiatives, there are many incentives for clearly documenting and coding the conditions that providers treat as well as the services provided.

Contrary to what some of you may have heard, ICD-10 in of itself does not require electronic records nor software for code selection nor additional patient testing. The pilot testing of ICD-10-CM used existing medical records, many of which were paper records.

The pilot testing, as well as the example developed for ICD-10 chapters in the Faye Brown's and other presentations we have done on ICD-10, use a simple PDF file that is publically available on the CDC and CMS websites. We have also seen at least one publisher introduce draft copies of ICD-10-CM and ICD-10-PCS in a book format. A quick review of these books clearly demonstrates that it is possible to code without software.

However, if a facility already has automated systems, there obviously will need to be a lot of hardware and software changes. And, again, that will vary from institution to institution, provider to provider, depending on what systems you have, whether they are from the same vendor, whether the

different applications communicate together, and whether you have systems that are home grown or commercially available.

And then you will need to consider data conversion. Not every system would need to be converted and so this would be dependent on a case-by-case basis depending on your needs. Decisions would need to be made as to whether you want to convert everything that you have, or only as needed, or only as required for specific types of analysis. Or if you do not need to compare against historical data, you may not need to do any data conversions at all. Again, this is not going to be a one-size-fits-all implementation process.

But for now - what you need to do is - and we're now on slide 49. What you need to do is to start looking at how you are going to tackle this big initiative. Obviously, because this crosses over into multiple departments, you're going to need a cross-functional team. This would involve collaboration among the different departments in order to identify which information systems are affected. The team would include members across clinical areas, financial areas, and information systems areas. You may be surprised to find that there are clinics that may have their own databases for a particular study that they are working on or there may be other data collection needs. There may be diagnosis codes that are manually entered directly into a database or they may be transferred from another application. So it's important that everybody is aware of what this change means.

But most of all, there needs to be support or sponsorship from administration to make sure that everyone understands and that timelines are developed. There will need to be support for trying to get the budget through and understand where things need to be prioritized. And obviously the HIM department leaders, as well as the coders, would need to be involved as well.

We are now on slide 50; some initial activities at this point would be to conduct a systems inventory. This is the only way you're going to be able to determine where those databases exist. You will need to determine what software programs you have, where they reside, whether you need to work with your commercial vendors to determine when they would be ready, and what their plans are for implementation.

On the other hand, if you have a home grown or proprietary program unique to your individual facility, you'll need to determine whether you'll have the resources available internally to make changes to those systems or whether external help will need to be acquired or whether you want to consider migration to something a little more generic that may be able to integrated with something that you already have from a commercial vendor.

No matter what you do, if you plan for future expansions in your information systems, you need to be sure that your vendors are aware of this change to ICD-10 so that you're not surprised later and these systems are not able to accommodate the new system.

We're now on slide 51. As far as timing is concerned - we have recommended that our members start preparations way before this time - actually before final rule, before an implementation date is set. So don't wait for the final rule because you're wasting precious time. So in order to even identify how long it will take for the implementation or what you will need to do, you need to get started right away - if you haven't already done that.

We have found that many hospitals had already done a basic gap analysis some time ago when we thought that the Notice of Proposed Rulemaking was going to come out earlier. But in any case, those plans and inventories would

need to be revisited because things may have changed in your facility since that time.

And once you realize and you decide where things need to change then that's when you'll be able to get a better idea of what the estimated timeframe for making changes or for making any software upgrades will be - because it will take time. It will take time not only to make those changes but to coordinate this effort across different areas within your institution. So if you haven't already done so, get your cross-functional team started. Start thinking about who you need to invite. And, again, remember that we do have time. You don't have to rush and buy full blown ICD-10-CM/PCS training at this point. There will be time to train the coding professionals. At this time, basically, you're trying to create the infrastructure of your plan - in terms of trying to figure out how you're going to proceed.

On slide 52, you have a number of links directly to the Central Office on ICD-9 and a section on ICD-10 where we're posting materials and information as we move forward and help you along with the implementation process. Ann?

Ann Palmer: Thank you, Nelly. Sue Bowman, who is Director, Coding Policy and Compliance, at the American Health Information Management Association, is now going to discuss AHIMA's role regarding ICD-10, including academic and educational plans, ICD-10-CM and PCS testing, and implementation planning.

Sue Bowman: Thank you, Ann. First of all, for those of you hold an AHIMA credential, you may report two continuing education units or CEUs for today's conference call. Simply report two CEUs as part of your reporting cycle. It is not necessary for you to have a CE certificate for today's program. Just keep a copy of the handout, the slide presentation, in case your CEUs are ever

audited by AHIMA so that you can show what the content of the program was about. It would also be beneficial, although not absolutely necessary - but helpful - if your organization is able to maintain an internal attendance record, also for auditing purposes to show that you and anyone else from your site who is claiming AHIMA CEU's, actually attended the program.

Note that these instructions only apply to those of you who hold an AHIMA credential. If you hold a credential from another organization other than AHIMA, you would need to contact that organization regarding their CEU requirements.

Today, as Ann mentioned, I plan to cover AHIMA's plans for transitioning our health information management, HIM, and coding academic program to ICD-10, our plans for educational and other resources to assist the healthcare industry with the transition, the results of the testing that's been done with ICD-10-CM and 10-PCS, and AHIMA's recommendations for initiating implementation plans and strategies.

Since coding is a core function of the health information management profession and improving data quality is a key part of our mission, AHIMA is committed to working with the healthcare industry to ensure a successful transition to ICD-10-CM and ICD-10-PCS. We have a long history of providing coding education and resources for coders and other health information management professionals working in a variety of healthcare settings.

And, in fact, we've been involved with ICD-10-CM and ICD-10-PCS preparation and planning including providing input to the development of the systems themselves, participating in testing of these systems, and developing resources for many years now. In addition to providing education to

experienced coding and other health information management professionals, AHIMA develops curricula for associate, baccalaureate and master's health and information management programs.

These curricula are, obviously, one of the first areas that will need to be updated to reflect ICD-10-CM and ICD-10-PCS so that our graduating students are prepared for a changing coding world. Currently our curricula at all academic levels currently has ICD-10 as a required knowledge cluster. As we move closer to implementation and once we know an actual implementation date, we will gradually expand the content of our educational preparation in the programs to include more and more ICD-10 training so that as students graduate, depending on the year they graduate, they will have the appropriate amount of ICD-10 knowledge at that time.

Our Education Strategy Committee is also working on developing a transition implementation strategy to pull ICD-10 coding, reimbursement, and change management in what we call knowledge clusters throughout our associate and baccalaureate model curricula. Master's level programs will also be updated to reflect changes in managerial and organizational skills required by moving to the new code sets.

We also are involved in approving some coding academic programs. So our Approval Committee for Certificate Programs will develop an impact plan for approved coding programs - meaning approved by AHIMA - including comprehensive training on ICD-10 included in that model curriculum.

Our virtual lab, which provides health information management and coding programs with virtual access to a full array of health information management technologies will also incorporate ICD-10 through our coding vendor that participates in that virtual lab development.

We will also call upon our relationships with our international colleagues through our International Education Workgroup of educators in order to benefit from other countries who have already converted to ICD-10 and are experienced with conversion strategies and help guide our process for academic programs.

A newly launched program called CourseShare, which allows health information management educators to share learning packets online so that people don't have to reinvent the wheel and can use other program's learning sessions in their programs, provides a very easy and quick way for updating the content of a particular module for an academic program very quickly because it's a web-based process to update that kind of content.

We are now on slide 58. In addition to our academic programs, we are also looking at a targeted educational model for defined ICD-10 audience segments, which the key categories we've identified for that include:

- Health information management and executive level leadership,
- Educators and current students - that I've already mentioned;
- Experienced coders in all settings;
- Data managers that may not need the same level of knowledge as someone who codes everyday, but needs to understand the differences in the coding systems and the impact on longitudinal data; and
- Care providers and others working within the healthcare organization that also need to have some level of knowledge and understanding of the new code sets, but not necessarily how to assign codes.

This targeted educational model will be tailored to address the varying needs of these different groups as well as over time leading up to the implementation date. Understanding the level of knowledge of these different groups changes as we approach the implementation date. And that once one group has been

educated, that there will be some type of maintenance program to ensure that they maintain that level of knowledge through the transition period leading up to the actual implementation date.

On slide 59, we outline some of our current ICD-10 resources that we have available already including two online courses that provide an overview of ICD-10-CM and ICD-10-PCS and, again, these are web-based courses. An ICD-10 Preview Book that we have available. We have an ICD-10-CM Proficiency Self-Assessment and we will soon have ICD-10-PCS Proficiency Self-Assessment.

We have an implementation preparation checklist that helps any healthcare organization guide themselves through the process of the steps that need to be implemented and which steps need to be implemented first. And how to do that process from now leading up until go-live implementation.

We have a variety of audioseminars that we have done which are archived and available through our website, and a variety of live conferences, a variety of articles in the AHIMA Journal - which are also available through our website. And our website is listed there on the slide and many of the resources I've just mentioned are available through that website.

We also conducted a free webinar for the industry immediately after the Notice of Proposed Rulemaking came out and that archived version of the webinar and the resource materials can be downloaded from our ICD-10 Page as well.

So if we move through the transition process toward implementation, we will be developing further, more detailed implementation guidance both for healthcare organizations who have the job of moving to ICD-10. Of course

coders who have a Coding or Health Information Management certification and need to continually maintain those credentials - we're looking at what changes need to be made to our credential maintenance process and requirements to ensure that our current coding professionals have demonstrated education and expertise in the ICD-10 coding system.

We'll be developing some practical change management tools including toolkits and checklists, talking points, and lessons learned about some things that are happening in the U.S. as we move forward as well as what our colleagues in other countries can teach us.

Now I'm going to talk a little bit about the testing that has been done of ICD-10-CM and ICD-10-PCS. First of all, for ICD-10-CM, AHIMA and AHA participated in and led an initiative to do field testing of ICD-10-CM.

The purpose of this project was to assess the functionality and utility of applying ICD-10-CM codes to actual medical records in a variety of healthcare settings and to assess the level of coder education and training that would be required. Six thousand one hundred and seventy-seven medical records were coded by credentialed coding professionals in a variety of healthcare settings. And it's important to note that while these people involved in the project were credentialed, none of them had any previous ICD-10 experience whatsoever.

Also, pretty much all healthcare settings were represented to some degree within the project including physician practices. Due to the constraints of the project, participants received only two hours of non-interactive training. And while that wasn't ideal - it wouldn't be what we would recommend for implementation - it was surprising how good coding accuracy and the understanding of ICD-10-CM was, even after only two hours of training.

And this was determined by a combination of a validation of the sample of their assigned codes to determine how accurately they were being assigned as well as reviewing the types of questions and comments that came in from the participants.

From the results, the participants indicated that ICD-10-CM was definitely a significant improvement over ICD-9-CM and that ICD-10-CM was much more applicable to the non-hospital setting than ICD-9-CM. The clinical descriptions in ICD-10-CM were thought to be much better, not surprisingly. And the notes, instructions and guidelines in ICD-10-CM were thought to be very clear and comprehensive.

One interesting result is that only 12.3 percent of the reported ICD-10-CM codes in this study were in the unspecified category - meaning that it had the word "unspecified" or "not otherwise specified" in the code description. As Nelly alluded to earlier, the small percentage of reported codes that were nonspecific in nature indicates that the medical record documentation necessary to support coding specificity appear to be present in the majority of cases. So we believe ICD-10-CM codes can be applied to today's medical records in a variety of healthcare settings without having to change documentation practices. Although, obviously, improved documentation would result in higher coding specificity and, therefore, higher data quality in some cases.

There's a couple of reasons why we thought that the unspecified codes were so low. One is that ICD-10-CM has eliminated a lot the - gotten rid of the - obsolete terminology and brought the terminology in the coding system up to date so that much of the code descriptions actually more clearly match the way the documentation was worded in the record. Also, many of the aspects that improved the specificity in ICD-10-CM, such as which side of the body

the condition occurred on, are typically often already in the record. It's just that they were not used in ICD-9-CM because it did not impact the ICD-9-CM code assignment.

In doing the survey, at the end of our field-testing project of the participants, the participant's felt that ICD-10-CM wasn't nearly as hard as they thought it would be going into the project. They recommended, as Nelly also mentioned, that training should occur three to six months prior to implementation - meaning training of the people who are actually going to be doing the coding. They felt that offering training earlier than that would be a waste of time and require coders to be retrained because if coders weren't using the ICD-10-CM codes everyday that they would lose what they had learned and would just have to be retrained closer to implementation. A majority of the participants indicated that about two days of training for ICD-10-CM would be needed to be fully functional using the coding system, which is consistent with AHIMA's estimate.

For ICD-10-PCS, formal testing was conducted by a CMS contractor who coded 5,000 records with an additional comparison test of 100 records. Participants in the formal testing received two days of training on the Med-Surg section of ICD-10-PCS and one day of training on the other sections.

Informal testing of ICD-10-PCS was also conducted by AHA and AHIMA volunteers. From the results of this testing, participants felt that after an initial learning curve, ICD-10-PCS could be used pretty easily. While ICD-10-PCS requires a greater understanding of anatomy in some areas, the Body Part Key being developed to accompany ICD-10-PCS should help with this. The Body Part Key translates anatomical sites likely to be documented in the medical record such as a specific bone - the body part terms used in ICD-10-PCS. So,

for example, you easily determine if a particular bone documented in the record should be classified in ICD-10-PCS for the hand versus the wrist. The participants felt that, not surprisingly, ICD-10-PCS much more complete than ICD-9-CM. And much greater specificity and the precision of ICD-10-PCS resulted in much greater detail about the nature of the procedure. The system is easy to expand and the multi-axial structure of ICD-10-PCS makes it easier to analyze. And the standardized terminology - once the coders became familiar with it - makes it easier to use once the coder has had that initial training because the terms always have the same meaning. And having all of the terms defined in ICD-10-PCS makes it much easier to teach.

Moving on to slide 62, we'll talk a little bit about AHIMA's recommendations regarding implementation, planning and preparation. The first stage of preparation involves assessing the impact of the change and identifying key tasks and objectives. An interdisciplinary steering committee to oversee implementation should be established in organizations that are large enough to have that.

The steering committee should develop organization's ICD-10 implementation strategy and identify the actions, people responsible, and deadlines for the various tasks required to complete the transition. The implementation plan should include the estimated budget needs for each year leading up to implementation as well as any post-implementation budgetary issues such as additional training needs, or the need for contractors to assist with coding backlogs, or resolution of identified post-implementation problems.

An internal timeline should be developed, including identification of the resources that will be needed. And this entire planning phase represents an opportunity to reassess and refine all of our operations so that we're just not

continuing to do the same old thing we've always done when areas of improvement present themselves.

ICD-10 awareness training should be provided to all affected individuals within the organization, so that people are aware of the coming transition and what it means for them in their area of responsibility, so they can start evaluating the impact and any budgetary implications from their perspective.

Staff education needs should be assessed. Who needs education and what type and level of education do they need? What method of education would work best for different categories of individuals in terms of effectiveness of training and cost?

And it's not too early to start looking at the medical record documentation and identify areas that would benefit from improvement. This represents an opportunity to evaluate the quality of the documentation for a variety of purposes and implement documentation improvement strategies as necessary. And you might be surprised during this process, at how much of the documentation to support ICD-10 is all ready there.

There's a widespread assumption that the increased specificity in the ICD-10 code sets means that significant changes in documentation will be necessary. However, you might find that much of the documentation is all ready present. As I said earlier, with the field testing project, ICD-10-CM uses up-to-date terminology whereas ICD-9 terminology is outdated so documented clinical terms may more closely align with ICD-10-CM than with ICD-9-CM. And there may be information documented in the record that is just not being used today because it does not impact ICD-9-CM codes, as I mentioned earlier.

So the first phase of this implementation planning process involves a strategic plan looking at what resources will be needed to implement the plan and budgeting for them, evaluating the total financial impact, developing objectives for the strategic process of moving to ICD-10, planning measurement tools, evaluation strategies to determine how the implementation is going and then planning the actual action steps for implementation.

The extent of changes to systems, processes, and policies, and procedures will need to be assessed. The changes that will need to be made to the various systems and applications that use ICD-9-CM codes or coded data need to be assessed. A comprehensive systems audit for ICD-10 compatibility will need to be performed. This includes performing an inventory of all databases and systems applications that use ICD-9-CM codes - giving consideration to how the ICD-9-CM codes are used in each system, where the codes come from. Are they manually entered versus imported from another system? How is the quality of data checked? And how do the interfaces between the systems work?

Software changes including field size expansion, alphanumeric code composition, redefinition of code values and their interpretations, and edit and logic changes need to be identified. Newer upgraded hardware and software requirements need to be identified and, of course, the associated budgetary implications.

On slide 64, there is a list of examples of systems and applications to be considered in this process. Obviously, this was not an all-inclusive list. And now is the time to start talking to your vendors about their awareness of the coming transition to ICD-10 and where they are with their plans and their process for moving forward.

All of the reports and forms that include ICD-9-CM codes will need to be identified because they will need to be modified to accommodate the new codes. For example, the superbills used by physician practices will need to be modified to reflect ICD-10-CM codes. An example of a portion of a superbill that has been converted to ICD-10-CM is shown on slide 65.

The complete version of the converted superbill is available on the AHIMA website on the ICD-10 page that was listed on one of my earlier slides. Also, the field testing report of the field testing project the AHA and AHIMA conducted can also be downloaded from the ICD-10 Page of the AHIMA website. And now I will turn it back to Ann.

Ann Palmer: Thank you, Sue. Dr. Jeffrey Linzer, who is Associate Professor of Pediatrics and Emergency Medicine at Emory University School of Medicine, Atlanta, and Associate Medical Director for Compliance Emergency Pediatrics Group, Children's Healthcare of Atlanta, is going to discuss ICD-10 implementation issues.

Jeffrey Linzer: Well, thank you very much, Ann. I know that a lot of physicians are very concerned about what ICD-10 is going to do for them and to them. And a lot of physicians are concerned that there's going to be changes in requirements for documentation.

Well, the good news is that the bad habits you learned in medical school will be able to continue through ICD-10. What you write now as your diagnosis is not going to change. If you were to write as a diagnosis fracture of the right tibia, then in ICD-10 that would be able to be distinctly coded as a fracture of the right as opposed to the left tibia. The information you wrote is no different than what you write now. ICD-9 is incapable of doing that. A good example in the pediatric world is in children who have recurrent ear infections. Currently,

when the physician would write an ear infection, you can't track what side it is other than a manual re-examination of the medical records.

With the new system in ICD-10, through the EMR, you would be able to document that the child may have had several recurrent infections of the right ear. And then this will be a benefit to the patient and it will help justify the reason why they may need to see a specialist for further management and training. The important thing with ICD-10 is that it gives us more specificity.

The important thing for physicians is that it does not require you to change how you document. What it does is help the coder who interprets your documentation to translate the information you all ready write into greater specific diagnosis to go into the EMR. It really is of a great benefit to our patients and really is not going to impact how we practice.

If you have a superbill, yes, you're going to have to adjust your superbill to sidedness, to add codes for left and right-sided, and for perhaps recurrence. But in the long run that is going to, again, be of a greater benefit to our patients. And, again, will not require any additional documentation.

The thing that's important to remember right now with ICD-9 as well as the upcoming ICD-10 is that the information that the physician writes in the medical record has to be translated into the ICD code. What we teach residents, what we teach medical students in documentation sometimes isn't sufficient to help the coder get that information across.

Currently, the coder will come and as they always say, "query the physician," when it's unclear what you've written. This is not going to change in 10, but perhaps through better training in the medical schools and residencies we will

be able to now cone down the information we are writing and be able to better document the information.

One other thing - this rumor still floats around about ICD-10-PCS replacing CPT and I just want to mention on this phone conference that, again, 10-PCS just replaces Volume 3 of the current ICD-9 manual and is only for use for the hospital to show hospital-based resources for inpatients. It will not replace CPT. It does not show physician work. It just helps demonstrate inpatient hospital resource utilization. So I just want to make sure I put that rumor to rest. Again, I strongly encourage you not to be afraid of ICD-10 and realize that it is going to be of a benefit without any additional work to the physician, to our patients. Ann?

Ann Palmer: Thank you Dr. Linzer. Dr. Lee Hilborne, who is the President of the American Society for Clinical Pathology, Professor of Pathology and Laboratory Medicine at the University of California, Los Angeles, Health Services Researcher and Consultant to the Rand Corporation of Santa Monica, California, and the Medical Director of Quest Diagnostics in Southern California, is now going to discuss ICD-10 implementation issues.

Lee Hilborne: Well, thank you Ann. I'd like to certainly concur with the comments that Dr. Linzer made just a few minutes ago and talk briefly about my thoughts about the transition from 9 to 10. Actually, I remember this original discussion probably when I just finished my residency a number of years back when there was discussion about moving from 9 to 10. And I'm actually glad to see that the discussion has now progressed to the point where there is actual talk about implementation. As Ann described, I have a number of roles and I've functioned and continue to function as a clinician but also as a researcher and administrator - having been associate director at UCLA Health Care and still responsible for care coordination in that setting as a medical director.

Long ago I realized that the purpose of coding had expanded quite a bit starting with its role in terms of public health and disease reporting, et cetera, later being added to reimbursement through the schemes that we're all familiar with. And now being used for quality assessment and improvement.

I think as we've been working with this - certainly on a research as well as somewhat on a clinical setting - it's clear to me that ICD-9 simply no longer has the depth or the capacity to meet the needs of all the stakeholders and that includes those of us who are clinicians. And so we have to change and other developed countries have. At the beginning of the presentation there was a discussion about the fact that 99 countries had adopted ICD-10 for broader use than we have here in the United States. I think that this will be a challenge and I don't want to minimize that. And I'm not personally sure about the issues of the timeline, but I really believe that that's not a good reason for us not to get on the pathway towards migrating from ICD-9 to ICD-10.

As Dr. Linzer commented - that the intent is not for ICD-10 or ICD-10-PCS to replace CPT - so those of us in our practices that are describing patient visits, radiology, laboratory procedures, et cetera, in the ambulatory setting will continue to use CPT-4 and its annual updates for describing the care that we provide in those settings. I think that hopefully the message came across.

And I've had the opportunity to work with my colleagues that were on the line with AHIMA, AHA, and CMS and have found that everybody collectively really wants to come together and work together on this. And so we need to really think of this as a partnership that includes the payers, government, the broader providers, and HIM professionals, and particularly those of us who are clinicians so that in fact the benefits that were talked about earlier for the transition from ICD-9 to ICD-10 are actually achieved.

So there's an opportunity for us to really get involved in those teams locally in our hospitals and in our practices to really plan for the transition. And to use the information that we heard today and others that will come forward as the future of the move actually progresses. Ann?

Ann Palmer: Thank you, Dr. Hilborne. Now going back to the PowerPoint presentation - on page 66 and 67 we have the CMS web resources - the general ICD-10 information, ICD-10 Notice of Proposed Rulemaking, the ICD-10-PCS Coding System and Training Manual, the ICD-10-PCS files, and the ICD-10-CM Coding System. And then on page 68 - we have the CDC resources, which include general ICD-10 information, ICD-10-CM files information, and general equivalence mappings between ICD-10-CM and ICD-9-CM. And then on page 69 - we have the AHA resources of Central Office on ICD-9-CM, the AHA Central Office ICD-10 Resource Center and the AHIMA ICD-10 general information on their website.

At this time, we will answer participants' questions regarding the topics presented during today's call. Please note the questions about the ICD-10 Notice of Proposed Rulemaking and specific coding questions are outside the scope of this call. Ken, could you please open the phone lines now?

Operator: Absolutely. At this time I would like to remind everyone if you would like to ask a question please do so by pressing star then one on your telephone keypad. Again, that is star then one if you have a question. I'll pause for just a moment to compile a Q&A roster. And your first question comes from the line of Nicole Avada. Your line's open. Nicole Avada, your line is open.

Ann Palmer: Let's go on to the next question please, Ken.

Operator: Okay. Your next question comes from Rochelle Miller.

Rochelle Miller: Basically, I had done that at the beginning cause I did not get the actual website on where I can go to get transcripts. We were unable to get PowerPoints.

Ann Palmer: You can go to www.cms.hhs.gov/icd10 and on the left side of that page you can see CMS Sponsored Calls. On that page you will find the transcripts of the calls once they become available and you will also find the ICD-10 Overview Presentation. They will all be found in the Downloads section towards the bottom.

Rochelle Miller: And you said it was www.cms.hhs.gov/icd10, correct?

Ann Palmer: www.cms.hhs.gov/icd10.

Rochelle Miller: Okay, thank you very much.

Ann Palmer: You can see that on page 66 of the presentation.

Operator: Your next question comes from Gary Goldsmith.

Gary Goldsmith: Hello. Thank you very much for the presentation. You know, while I can appreciate the need for ICD-10 in the hospital setting, I can't help but get the feeling that you've left the physicians out of it with the exception of the fact that they're going to be documenting.

What about the thousands of physicians that have solo practices and the thousands of physicians in small group settings that don't have professional coders that, in fact, do their own coding at this point? What do you expect from them when it comes to ICD-9 coding - ICD-10 coding? What do you

expect their learning curve and their training programs gonna be? And people were talking about this is not going to be a major impact when it comes to implementation. I can understand that from a documentation standpoint but for a small group practices that depend on the doctors to do the coding this is going to be a major disruption, besides the cost to implement this. And I just want to get a feel from everyone because it seems the - that nobody was responding to that. Everyone was assuming a professional coder was going to be doing the coding here.

Pat Brooks: Sue, do you want to respond to that from your perspective if you were assisting physician offices who did not have a coder - what kind of targeted training you would develop?

Sue Bowman: Well, this is Sue from AHIMA and, actually, we are definitely looking at resources and working with anyone who needs to implement or learn ICD-10 - whether they have a professional coder or not which may involve collaborating perhaps with some of the physician organizations, or some of the physician specialty groups, or the State medical societies, or something like that.

But we definitely recognize that the training is huge and that there's a huge number of people in a variety of different circumstances with different resources and different needs who need to be trained. So we are definitely looking at how best to provide that. So we're not at all just focused on looking at training for our own members or people who are professional coders - for sure.

Gary Goldsmith: Still on the line? Hello.

Ann Palmer: I'm sorry.

Gary Goldsmith: I was just going to follow up with the idea that we're looking at implementation dates possibly of October 2011. And, again, I'm not going to concentrate on professional coders. I'm only going to concentrate on the tens of thousands of physicians out there that don't have professional coders, and the cost, and the need to totally change their coding systems. I mean, this is not a - obviously this is not an easy thing that's gonna be done. It just seems that everyone seems casual about this and, again, we're looking at the clock ticking. Three years from now, possibly, we could be implementing this. And I keep thinking of everything else we've tried to implement in the last couple of years that has taken a lot more of a toll on the doctors than people anticipated. So, again, I just wanted to give you my comments on that.

Pat Brooks: This is Pat Brooks from CMS, and we do appreciate those comments. And we are going through formal comments as part of the rulemaking and looking at timeline issues. And one thing I can say, if a final rule goes out with a final implementation date, we would look forward to working with various industry groups, professional societies, maybe AHIMA to facilitate outreach and training.

Obviously CMS would not be a technical training leader but we've given this overview and we would want to do more overview stuff. But we would want to encourage and work with groups to see what kind of training was needed and how we can help facilitate its appropriate development. So thank you very much for those comments.

Sue Bowman: This is Sue from AHIMA. I just wanted to add that we certainly recognize there's a lot of work involved here but if there's any positive news or positive aspect, one of it is, as Pat mentioned when she was covering some of Donna's slide earlier, there were a lot of physician groups involved in the development of ICD-10-CM. And we all know that there's actually a lot of physician

frustration with ICD-9-CM, that the codes aren't really structured the way they talk, the way they think. And there was a lot of physician input to the development of ICD-10-CM.

So we are actually hopeful that the terminology will be more like the way physicians think and from that perspective at least will make it a little easier recognizing that, of course, all the systems and everything will still have to be changed. But maybe it will seem a little bit more user friendly and logical to the physician community. And I don't know if Dr. Linzer or anyone has anything to add to that.

Jeffrey Linzer: This is Dr. Linzer from Atlanta. I would say that in the long run, I don't think it's going to be that major a cost issue to the small groups or single providers. What is documented in the medical record, as I said, is not going to change. And as far as your superbill goes - if you look at the example that AHIMA has posted in the slides - you can see that the conversion is really not all that difficult. I think several of the major societies are already assisting their members looking at this change. And probably the biggest effort that will come for the provider is what will be placed on the 1500 or what will replace the 1500 in the actual billing.

Operator: Your next question comes from Diane Glasser. Your line's open.

Diane Glasser: Hi, my question was answered. Thank you.

Operator: And your next question comes from Mary Harrison. Your line's open.

Mary Harrison: Yes, thank you for the presentation today. We're looking at - I've got a representation of several certified coders and our question goes back to the Cooperating Parties. And most of the coders here are represented by the

AAPC and not an AHIMA in our area. Are we going to be able to utilize AHIMA's website and the tools that they're developing if we're not members of AHIMA?

Sue Bowman: Yes, absolutely. Many of the resources that I referenced are actually publicly and freely available on our website already. And so we do have a - you know - our resources are not limited to our members.

Nelly Leon-Chisen: This is Nelly from the AHA, and I echo what Sue just said. All the references that I mentioned are also available to anyone, including our Central Office clearinghouse function is available. And you don't even have to be a coder. You can be a physician, you can be a payer, or a vendor, or anybody who has a question on the codes.

Mary Harrison: Okay, thank you.

Operator: Your next question comes from Nancy Reid.

Nancy Reid: Hi. Thank you for your presentation today. I have a group of credentialed coders here and we would kind of like to disagree with Dr. Linzer on the information that he said about documentation really is not going to change for the doctors. We think it will because if you have a fracture of a tibia of the right leg, you still have to say where it's at - proximal end, distal end, you know, shaft, epiphysis, whatever. So the documentation - they're still going to have to give us a little bit more. So I don't think that statement was quite right. The same thing for, you know, fractures of the hand or the radius. You still have to say where on that bone for that fracture. So I think that the documentation for doctors is going to have to be a little bit better. And as far as the doctors that don't have credentialed coders working for them, I'd like to

give a plug for all of those credentialed coders out there that would be, I'm sure, quite helpful in their journey into ICD-10. That's it.

Pat Brooks: This is Pat Brooks. I'll respond before Dr. Linzer does. I just want to point out the good and the bad news with ICD-10-CM is that you can be just as vague as you want in your diagnosis and, unfortunately or fortunately, ICD-10-CM has codes "not otherwise specified" all through the book. So if all you know is you fractured something, you don't have to have any more detailed information than you do with ICD-9-CM. There are default codes throughout each category. Obviously, you miss taking advantage of the left or right or the distal end or whatever. So if you'll go through the various sections of the code, you'll find that there are "not otherwise specified" codes there. And Dr. Linzer, I don't know if you want to add any more to that.

Jeffrey Linzer: Yes, I'd just like to comment. I think that physicians now document in a certain manner. And if the physician writes fracture, right distal tibia, that's what they're going to write in ICD-10. The important thing to note is 10 doesn't require the physician to write with more specificity. Pat is correct that there will still be the relatively nonspecific codes in 10. It just allows for those physicians who do write in more detail to have that information translated into 10. But there's no requirement that the physician has to write more than what they write now.

Operator: And your next question comes from George Van Yek.

George Van Yek: Hi, good afternoon. I totally disagree with Dr. Linzer and everybody else, for the most part, that is providing the meeting. I read through the first transcript from the hospital meeting. There are a number of difficulties with the new classifications - drills down to too much specificity. Now, I run an orthopedic practice. I have three physicians that work at a lot of different places and their

method of - I'll be polite and say - the way they make their living is by making sure that they treat patients as, obviously, as efficiently as possible. Efficiency with this diagnosis code style or format is too slow. I'm looking right now at the fracture coding for patellas. There are somewhere in the neighborhood of 36 different codes. On top of that, then you have the initial encounter, initial encounter, subsequent encounters, type of fracture.

We as physician practices - whether "we" being a doctor, whether it be an office manager, or a coder - bottom line is our goal is to provide sufficient information to be able to make sure the patient's treated properly - proper follow-up and at the same time be able to make a living. The level of specificity in this particular case is so high or so detailed that - I'm looking at F, the sub letter F, I guess that's probably a seventh code or subsequent encounter for open fracture type 1A, or 3A, 3B, or 3C with routine healing. And then it has delayed healing, nonunion, malunion.

The time constraints - my physicians code through superbill. I know of no practice that has a superbill that looks like what AHIMA has. I've never seen it before in my life - seen lots and lots and lots of them. Bottom line is - is - the procedure code is what the physician's paid off of. Diagnosis codes, if you'll pardon the expression, are extra information. Our reimbursement is based upon the procedure code and if we don't have and the procedure codes are not great.

And there are benefits definitely to the 10 format. The difficulty is that I think everybody has decided that going down to the nth degree specificity is a positive thing and it's not. No physician that's operating a medical practice and codes for themselves is going to be able to reasonably provide accurate coding in a reasonable period of time. I currently have with my physicians a single sheet, very small list of diagnosis codes for a quote a "cheat sheet," standard

codes that they use on a regular basis. At this point - from what I'm looking at - you're talking about a minimum of three sheets in order to be able to get remotely close to what would be available. I don't know. Somebody say something.

Pat Brooks: This is Pat Brooks. I guess, well, the only thing I can say, once again, is that if you did look up - not that I'm encouraging this but - a fracture of the patella, you can get through to unspecified one that doesn't tell exact location or whether there was a - it's - an initial or subsequent encounter. So that codes out fairly quick. You are correct that if you want to supply better detailed information for people to use in outcome settings - like if some people in your profession have been encouraged enough about registry for various things - then those people would be more interested in probably spending more time getting the better data. But ICD-10-CM does allow you to imprecise and to use those imprecise, unspecified codes on your superbill should you choose to do that - not that I'm encouraging the use of less specific codes. But we do appreciate what you've said there.

Sue Bowman: And this is Sue. I would just also add that much of this increased specificity - almost all of it I would say, actually, interestingly enough - it comes from the physician community. In the slides that Pat went over on 17 and 18, which is just a partial list of the physician groups that looked at ICD-10-CM, much of the specificity was requested by these groups as felt to be clinically important.

Operator: Your next question comes from Jan White.

Ann Palmer: Hello, Ken?

Operator: Yes, ma'am?

Ann Palmer: This will be our last question.

Operator: Very good, ma'am.

Ann Palmer: Thank you.

Jan White: So I actually have three questions. I keep hearing "if this is implemented." What is the likelihood that it will not be implemented?

Pat Brooks: This is Pat Brooks. The reason I say "if" is because we're in rulemaking. What we have done is - we have proposed to replace ICD-9-CM. I'm not in the position to say what final decisions would be made. Part of rulemaking process and clearing of a final rule would be to say if ICD-10 were implemented and the date. So at this point we have nothing definitive to say about the final rule and what it might say. You would have to wait and see when that is posted and what it says. That's the reason I gave those caveats.

Jan White: All right and then you said the extension would be up to seven characters. How likely is it that in the future it will increase even more?

Pat Brooks: This is Pat Brooks again and the 5010 rule, which is a totally separate rule, talks about the ability to capture these codes. The plans within both 5010 and ICD-10 are for a maximum of seven digits.

Jan White: Last question - the procedure codes are for inpatient. Would that include all types of inpatients - such as psych, or nursing home, inpatient stay - or is it strictly acute care hospital?

Pat Brooks: It's acute care - nursing homes don't use ICD-9-CM procedure codes. So if it was an acute care inpatient that today is using ICD-9-CM procedure - and

they know who they are - then they would know that if the final rule comes out and gives them an implementation date for ICD-10, then instead of using ICD-9-CM procedure codes, they would switch to ICD-10. We're not proposing to implement ICD-10-PCS procedure codes in any setting where ICD-9 procedure codes are not currently captured.

Ann Palmer: Okay, well, thank you for your participation.

Operator: This now concludes your conference call. You may now disconnect.

END