

## **“Impact of ICD-10 on Safety Net Providers?”**

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### **Panelists:**

- **Quang Ngo-Texas Organization of Rural & Community Hospitals (TORCH)**
- **Christi Dant-Centers for Medicare and Medicaid Services**
- **Gervean Williams –National Association of Community Health Centers**
- **Dr. Victor Freeman-Health Resources and Services Administration**
- **Anthony Oliver-Health Resources and Services Administration**
- **Yael Harris-Health Resources and Services Administration**
- **Mary Washington-National Opinion Research Center**

**Anthony Oliver:** Thank you very much, operator. Good afternoon, everyone. On behalf of the Health Resources and Services Administration, I'd like to welcome everyone to today's Health Information Technology and Quality webinar, titled: The Impact of ICD-10 on Safety Net Providers.

Before we start today's presentation, I'd like to make you aware of the HRSA Health IT and Quality websites. These sites contain toolboxes, additional resources, as well as archived copies of previous webinars. An archived copy of today's presentation should be available for viewing within two to three weeks on these websites. Viewers can also submit any questions for us to send to [healthit@hersa.gov](mailto:healthit@hersa.gov). Requests to receive electronic copies of today's slide presentation can also be obtained by sending a message to this email address.

Today's participants should be aware of the recently released Health Information and Management System Societies Job Mind for Safety Net Providers, which allows members of the Safety Net community to post resumes and search for physicians free of charge. September 12<sup>th</sup> through 16<sup>th</sup> was designated as National Health IT Week. There were several activities which took place to honor this event. Please see the HRSA Health IT website for information on the HRSA activities for that week. The Department of Health and Human Services also held a consumer health IT summit during that week, which featured the release of a voluntary personal health record privacy notice. An archive of the webcast can be found at the [hhs.gov/live](http://hhs.gov/live) site. Additionally, the National Health Service Corp will be hosting its first annual core community service date on October 13<sup>th</sup>. Please see the corp website for additional information and resources. Please mark your calendars for the next HRSA Health IT and Quality webinar titled: Tips for going live with an HER system, which will be presented on October 23<sup>rd</sup> at 2:00 pm, Eastern Time. Additionally, last month's webinar on privacy and security is now available for viewing on both the HRSA Health IT and Quality websites. Participants of today's webinar may also wish to visit the ICD-10 for Safety Net Providers and the CMS ICD-10 websites for additional information and resources related to ICD-10.

I'll now turn the webinar over to Dr. Yael Harris, the director of HRSA's office of Health Information Technology and Quality who will introduce today's presenters. Dr. Harris.

**Dr. Yael Harris:** Thank you so much, Anthony, and thanks to all of you for joining. I'd like to welcome all HRSA grantees, members of the Safety Net Community, and any others to this Health Resources and Services Administration, Health Information Technology and Quality Assistance Technical Assistance webinar.

Today's presentation is entitled: The Impact of ICD-10 on Safety Net Providers, and we'll provide technical assistance for how Safety Net providers can plan and implement the changes necessary to comply with the health industries conversion to the new international statistical classification of diseases and related health problems, also known as ICD-10 Coding System.

As a pre-requisite to ICD-10 compliance, healthcare organizations are also required to adopt updated electronic transaction standards known as HIPAA 5010 by January 1<sup>st</sup> of 2012. Failure to address this issue in a timely manner may actually lead to the inability to bill Medicare and Medicaid. Providers who have not begun the planning and budgeting process need to become more proactive and work with their billing and health information technology providers or managers to assess where their operations stand relative to the ICD-10 final rule. Developing strategic plans and taking action now will help to mitigate late stage rushes for compliance during the last months of this calendar year.

Today's speakers have firsthand experience working with Safety Net providers on ICD-10 conversion issues. They will discuss the ramifications of failing to make compliance deadlines and highlight ICD-10 resources that are available to Safety Net Providers. In addition, they will touch on the strategies to avoid implementation bottlenecks.

Before I introduce these afternoon's presenters, I would like to read a disclaimer. First, I would like to add that this webinar is intended to serve as a technical assistance resource based on the experiences and expertise of independent consultants and HRSA grantees. Its contents are solely the responsibility of the authors and do not necessarily reflect the official views of HRSA. In addition, HRSA does not endorse any health IT vendors or software systems, including any systems featured in this webinar.

Now let me take a moment to introduce this afternoon's presenters. We will be starting with Ms. Christi Dant. Ms. Dant currently serves in the Office of E-Health Standards and Services at the Centers for Medicare and Medicaid services where one of her key responsibilities includes outreach to the federal sector on ICD-10. Prior to joining CMS, Ms. Dant owned a consulting practice, which primarily focused on the areas of public health, health information technology, and health information exchange. Ms. Dant served as a reviewer and chair for a variety of HRSA and HHS grant programs and has provided technical assistance to HRSA Section 330 Grantees. Ms. Dant's prior experience also includes working in HRSA's Bureau of Primary Healthcare as a project manager for the Community Access Program, as well as holding various positions in the state and local governments of Connecticut, South Dakota, and Minnesota.

Following Ms. Dant, we have Quang Ngo. Mr. Ngo is the President and Chief Executive Officer of the TORCH Foundation, a non-profit affiliate of TORCH. Mr. Ngo has 10 years of experience in Rural Health and Program Development, having worked at the Texas State Office of Rural Health, where he oversaw the states Medicare Rural Hospital Flex Program. His background

includes experience in the areas of public health, health services organizations, health policy, and project management. Mr. Ngo attended Trinity University for his undergraduate studies and the University Of Texas Health Sciences Center School Of Public Health for his graduate studies.

After that we are fortunate to have Gervean Williams. Ms. Williams is a Director of Finance and Operations in the Training and Technical Assistance Division of a National Association for Community Health Centers. Ms. Williams's prior experience includes holding Chief Financial Officer positions at both the Samuel Rodgers Health Center and the Shawnee Mission Physicians Group. She has also worked in the field of public accounting at the regional firm of Baird, Kurtz, & Dobson. Ms. Williams is a former Rodgers board member, Co-Chair for the Mid-America Regional Council HIT Committee, and has also served as a member of the Diversity Council for the Saint Luke's Health System.

Finally, Dr. Victor Freeman will be providing the final presentation. Dr. Freeman is a Senior Medical Advisor on Quality and Public Health Issues within HRSA's Office of Health IT and Quality. He comes to this federal role with a quality improvement background that includes having served as the Medical Director for Quality for a four hospital health system in Northern Virginia. He has been recognized for his leadership work and local community advocacy for safety net hospital and clinic services in the Washington D.C. area. Mr. Freeman is a graduate of Harvard University and Stanford University Medical School.

I want to take this moment to thank all of you who are participating on the phone and all of these speakers for taking the time to help educate those on the call. Now I'd like to turn this event over to Ms. Dant.

**Christi Dant:** Thank you very much, and we have a great deal of appreciation for HRSA's tremendous interest in getting the messaging out regarding 5010 and ICD-10. It's not always the happiest news for everyone to receive, but we are excited about the potential and I'm going to talk a little bit about where we're going and how we're going to get there together.

The first thing you need to know, and you're probably aware of because you're on this call, is that the deadlines are coming quicker than we think, and it's much more complicated to get there than we had hoped. I'll talk a little bit about version 5010 because -- first because, number one, that's the next deadline, and it is actually the platform from which ICD-10 will be able to function. Basically what you need to know is the deadline is not moving. It is fixed; it will be January 1<sup>st</sup>, 2012. And I appreciated the reminders at the beginning of the call that this is a great time for you to be speaking with your vendors to find out where they are, to really push to make sure some testing is getting done before everybody kind of piles up at the end. CMS is ready to go on 5010; we are already receiving and processing 5010 transactions. So we're ready to go. One of the reasons the deadline is not going to be moved, quite frankly is because there are options for compliance, and those include signing up with clearinghouses; there's also free software for Medicaid -- Medicare fee for service (That one is hard to say.) providers, and that's available for your MAC. That software of course, it may be free in cost but it's not a simple implementation, so we encourage you to work with your current vendor, and there is also the option for paper and phone. We have heard from industry, both sides of the argument; push it back, move it ahead, but we're hearing more voices that we need to move forward because so

much is going on and you're all a part of it. I don't need to bring that news to you that there are a lot of -- we've put a lot on your plate and we know it.

Version 5010 basically is a background operating system kind of -- I think of it kind of like the Windows Operating System. Some people may not be aware its running, but it's what helps make the transactions flow properly. And 5010 fixes many of the shortcomings in 4010, including a lot of the Part D transactions, so it's critical to get that part underway.

The next big piece that we're looking at, and this is far -- has far greater implications as ICD-10. For those of you who don't know, I'm just going to do a tiny bit of background. I'll be honest with you; I didn't know ICD-9 or ICD-10 when I started at CMS just a year ago. I have worked with the data derived from ICD-9 and 10 in quality and in all kinds of different manifestations, but I was not aware that the source for a great deal of how we make decisions on funding and disease management, UDS reporting, all kinds of quality reporting, has its roots in that simple ICD-9 code, and it is a code set that has been exhausted. It does not have room in it to add a litany of new procedures. The good news for the community health centers, and those of you who are not hospitals, is that you won't have to be concerned with learning the procedure code set, which is really quite large and robust, but will instead focus on (Excuse me for my misspeaking today, I'm a little nervous, this is a really large crowd today.) the diagnosis codes. So the training implication for community health centers and providers is a little bit less rigorous than for the hospitals.

Let's jump down to who's affected. The quick answer to that is everyone, everyone in healthcare. A lot of people are operating under the assumption that this is a Medicare or Medicaid, it is not. Anyone who has a HIPAA covered entity must use ICD-10. Those... In there I did see a question on there, will this affect paper applications? And that may or may not lag, but every single -- you need to look at every single contract you have with every insurance company to see how they intend to handle other options other than being fully compliant. So it's not just Medicare and Medicaid, you have to look at Aetna and the state Medicaid agencies, they are all mandated to be using ICD-10 as of October 1<sup>st</sup>, 2013. That date is not changing. That date is a hard switchover. It's not being phased in, there's no small provider exemptions; that is the date. You can imagine the Federal Enterprise as both as a payer, a direct provider, a funder. We use the ICD data to inform policy. The historical data, the research, surveillance epidemiology; so many systems are impacted and it's not just clinical systems, its research, its business processes. So the federal factor, at the same time they're trying to support grantees and providers, are also having to undergo major systems transformations. CMS's own project has been underway for two years. We have posted an incredible number of resources. So the time of that is, for now -- let me try that again. The time to prepare is now. There was some wishful thinking that we had pushed back, and I would remind folks that ICD-10 was already pushed back once by two years to allow additional time for compliance, and it is our belief that now the tipping point has been passed. Major entities, millions and millions of dollars have been invested in time and timing to make ICD-10 happen. There is not the capacity to delay the entire system for a normal distribution curve of folks who may or may not be ready. But we are developing tools and strategies to help the smaller providers. CMS will be launching and posting, and we had hoped to have it up by now, a small providers handbook that gives absolute step-by-step down to the templates and who you need to talk to and who needs to be involved in the process,

and that will be going up on our website. We'll blast it out through the huge number of other federal entities we're working with; HRSA is number one on the list. But also we're working with the National Association of Community Health Centers, all the Public Health Information Technology Associations, and our website of course is full of resources. We are refining that content to make it easier for folks to be able to find what they need specifically for them, because we are dealing with the entire healthcare sector - payers, providers, funders, VA, DOD. So the net that we have to cast is very, very large, and we really appreciate any feedback we can get on how to best post those sources and get them out. But I encourage you to work closely with the HRSA folks who are going to be doing some of that filtering of resources and posting. They gave you the website address, and I would suggest that they be a primary go-to, simply because they link to us, they use our resources. There is an ICD-10... If you see at the bottom of the slide there is an ICD-10 logo which designates that it is an official resource from CMS.

I got a little ahead of myself on the slides because I wanted to respect the amount of time available for the other speakers. I put up a couple slides in here, just some of the available resources and what they look like on our website. There is one, it's my absolute favorite, but it's named something really strange and it's hard to find. But it's called Artifacts and it literally has just about any template you can ever imagine needing. Another great source when you're talking about training your coders is the American Association of Professional Coders, HIMSS and AHIMA have also put out a litany of tremendously good resources.

The one thing that I would encourage you to do over and over again is to make sure that you are talking to all of your vendors, all your partners, and assuring that you can get there together. It's really important to poke through all of your processes and find where ICD-9 codes or derived codes inhabit your processes. I know HRSA is very cognizant that UDS requires ICD-9 codes currently, and they're addressing that conversion, but there are also things to look at, such as UDS being a calendar year report and our switchover is on the federal fiscal year. So there are a lot of things that need to be planned for that on the surface. Until you start really digging around and talking to everyone, you could well get lost. So it's time to have some really robust conversations. The degree to which you can partner and work within your networks and share resources will really be vital. We do anticipate there will be tremendous stress and demand on vendors and consultants as we get closer to the ICD-10 conversion. So by delaying, you could very much put yourself at risk of not being able to get adequate resources in a contractual way, looking at train the trainer. One very close thing to look at is the potential for changes in staffing. What we know today is that only about, out of hospital bills, only about one in five is processed without additional calls, without additional submissions, and ICD-10 is going to really help eliminate some of that rework that gets done. However, we have also found based on the Canadian experience that coders don't get back to the same speed of coding because they don't do as many, the same number of files because it is a little bit more intensive, but the savings is in the rework, it is in the responsiveness and quicker payments on claims. So there are a lot of balancing factors, but they aren't going to self balance, it's going to take strategic decisions on who you put in what positions, who you train. We recommend having access to an ICD-10 coding trainer and sharing those resources.

There are just so many areas to hit and I know I've missed on several key items and I'll try to hit those in the Q&A, the website, and some of the other presenters will also cover many of the

things I've touched upon. Again, please, please, use the resources that are being assembled for you, and call on us if you should need more assistance. If we're missing something, communicate that through to us and we will attempt to the degree humanly possible to answer your needs. That will conclude my presentation.

I'm going to now turn it over to Quang.

**Quang Ngo:** Thank you very much. As the slides get loaded. Thank you for the opportunity to present on our program. I think in the 15 minutes that I have, I think what will be most helpful is to go over a few things, on one, let's spend just a minute or two on TORCH and its role in the development of this program, and how we were able to pull different partners together as a resource for our role in community hospitals here in Texas. Then, spend the bulk of the time really talking about the framework and structure of the project itself; who does what, who funds what, and hopefully how we're able to continue to help guide all hospital members in the next couple of years toward the compliance date.

First, this pictorial illustrates sort of how everything hangs together here at TORCH. TORCH is a Texas Organization of Rural and Community Hospitals. I serve on both capacities both at TORCH as well as the Foundation. TORCH really started 20 years ago as really the principal advocate and voice for rural and community hospitals in Texas. We represent 150 hospitals all throughout the state and provide the full range of services that are very much member driven, member needs. So this, each of the areas here really represents a strategic key area of focus that we provide certain programs and activities for our members. Obviously as a membership organization, we do have a strong focus on membership. As I mentioned, there's 150 hospitals that we represent. We work extensively with the corporate folks, as well as folks in the government industry. We have an association management focus. What that really represents is that in addition to the hospitals, we have contacts and experience and exposures that reach out beyond just hospital members to rural health clinics. We run and operate the Rural Health Clinic Association here, there are about 130 clinics. About half of those are hospital based, and the other half are independent clinics, so we do have activities that extend to the clinic side as well. And then we also operate the home health, hospital based home health agencies, and there are about 100 of those, and so there are activities that impact them. We do have a full profit arm that focuses primarily on management services, consulting services, specific again to those key areas of impact for small rural community hospitals. We do provide a number of services, the UPL programs on the Medicaid side, policy banks insurance program, HR resources, and of course as an advocacy organization, representation -- legislative representation is an extremely important factor for our members. We have started a leadership institute some years ago, and that's a great area that's growing where we have interaction at all levels of the organization. There are a number of hospital organizations, as well as all of the universities and industry folks who have come together really to support leadership development, local capacity development for our members.

Then the TORCH Foundation, as was introduced in the introduction, is the 501(c)(3) non-profit arm of TORCH. Our main focus on the foundation side is to leverage and seek grant funding and partnerships in the industry in order to pull together resources to develop program and services for our members. Our main focus area today resides in the area of Health Information

Technology, education obviously, as well as providing grant supported programs and services for our members. On the grant programs, I'll just mention real briefly, in addition to the ICD-10 readiness program, we have other programs like the meaningful use assessment programs, the HIPAA Risk Assessment Programs, the Patient Safety Organization Programs. Most of these are all grant funded, grant supported programs that are available often at no cost to our member hospitals. So we do get great interaction and great participation on their part.

This is a graph of where all of our members are located. So as you can see, Texas is a big state, and our members are located everywhere. About half of the memberships are critical access hospitals, so we do represent hospitals that are as small as 14 beds, 14 bed critical access hospitals to those upwards of 200 beds. The majority of our members, however, are roughly under 100 beds. So these are the Safety Net Providers, these are the folks that are mainly the main sort of economic driver, the center of their community, and so it's vitally important to make sure that we do everything we can to help them position themselves to be viable within their community.

So to the ICD-10 readiness program, this is a collaborative process, a collaborative partnership between three main parties. This is a grant funded program through the State Office of Rural Health. If you're in Texas, they were called the Texas Department of Rural Affairs. They have recently in this legislative session became part of the Texas Agriculture Department, and they're the funder for this program. So quite some time ago, we have gotten together with the Texas State Office of Rural Health to discuss the impact of ICD-10 on our rural hospitals. This discussion started beyond, I think actually back around May of last year, so May, June, of last year, as everyone was busy implementing EHR and reaching meaningful use status. We wanted to make sure that ICD-10 didn't go by the wayside, and that that was the next big wave as well. And in fact, that has immense implication in the way that most other hospitals would implement the EHR technology. And they had to make sure that there were capabilities and functionalities in the systems they were evaluating to make sure that it could support ICD-10 coding in the future. So it was quite -- it was an integrated type of discussion, a lot of education that came out of that, and luckily we were successful in securing some grant funding to begin the planning and development of the ICD-10 Readiness Program, so that program is administered through the TORCH Foundation. So once the grant was available, we went to work with our partner, QuadraMed Corporation, who we had been working with on the EHR side for some time. But, as they were one of the experts in the ICD-10 in the industry, and in fact the only one at the time that has a coding simulator, there was great synergy between the state office, the TORCH Foundation, and QuadraMed to get together and begin to develop an education and training program to provide some early resources for our member hospitals. As was mentioned in the previous presentation, we wanted to do this early because we wanted to avoid implementation bottleneck, and a lot of the hospital think that since 2013 is quite a ways away, we wanted to make sure that we properly educate them and let them know about the urgency and impact of this across the organization and not just within the coder community. So we got going quite quickly on that.

And the program, as you can see from this slide, really the main benefits of the program for us is that we convey to them is really to comply with the federal mandate for the ICD-10 compliant, but more than that is to get early access to coding simulator technology that provides them with

some real hands-on training and technical assistance. As part of the program, we also develop customized online education webinars, both for the HIM staff, as well as for the medical staff, and the Steering Committee, in the hopes of buying -- of getting physician buy-in. Part of all this education is to allow them to be familiar with the transition between the 9 sets and the 10 sets, and learn what some of those key elements are in the differences, that we'll then later translate to much greater specificity in the coding and documentation, as well as ways in which they can begin to reduce coding errors and improve some of the reimbursement process along the way. And of course because its grant funding, it would be of no cost to the hospital, and so what we get as a result of that is tremendous participation early on.

Specifics -- some specifics to the ICD-10 Readiness Program, here are some of the activities that are comprised. And again, this is just one of the ways in which an ICD-10 program could be rolled out. Here's an example of how we set it up here in Texas working with three partners. The main component of this program obviously is the countdown coding simulator. Again, as I mentioned, this offers hands-on training of any technical assistance. Really what this is an online system where we would use grant funding dollars to purchase access to or a subscription to the program. Hospitals would then get on, log on, and would be able to not only learn the differences, the various information about fundamentals of ICD-10-CM and PCS, but also have application tutorials that they can learn on their own pace, and also be plugged into the ICD-10 community bulletin board, which provides them with resources and information within a community base of experts elsewhere in the country that they can have their questions answered. Once they get in, they're able to, almost like an avatar, be able to create scenario, mock scenarios, and begin to practice on how the coding difference is between the 9 set and the 10 set would look like. I failed in the presentation to actually provide you with some screen shots from that and what that system looks like, but very much like a Web-based application, it has different functionalities and features, one of which is coding and abstracting. So they're able to go in and look at different classifications of diseases and injuries; they're also able to go in under the compliance and look at all the rules and regulations with respect to compliance issue. There's a module for record management, that they can learn how to do that, as well as one for patients, file managers, and administration. So it's actually quite comprehensive, and they're able to go in early, play around with it, and learn how the differences and the specificity from a documentation standpoint actually works. So that's a great first feature, and we were work from a programmatic standpoint to ensure that all the hospitals have all the necessary details, specifics on how to get into, and we actually guide them along the way from the standpoint of accessing the various different online education modules.

In addition to that, we also have throughout the year educations on ICD-10 and training webinars where we provide information that's specific to coding staff, to the medical staff, and to the what we call the Interdisciplinary Steering Committee. What those webinars do is they actually cover specifics. So within the HIM coding staff webinar, these cover the regulatory process for ICD-10 adoption, it covers implementation and timelines, and provides education and training on the structure, the organization, and the unique factors that are specific to the ICD-10-CM/PCS coding. For the medical staff webinar, we discuss the value of the new code sets; what are the differences between the Legacy System and the new coding system, and how that translates to impacts on their documentation practices. In the Disciplinary Steering Committee, as I mentioned before, that's really an effort to pull key staff from all the various different

departments in an effort to illustrate that this is more than just a coding exercise or a coding transition, it really is an organizational wide transition, and so there is important implications in terms of changed management and buy in and ongoing training that involves not only coders but also physicians and other department head.

We also, on our own as part of the program, provide online other webinars that are outside of what we work with, who is QuadraMed, our partners. We also provide what we call TORCHcast. TORCHcast is our webinar program that we run, at times, twice a week, or twice a month, I'm sorry, and we provide various different live webinar educations on ICD-10 updates. Oftentimes we have folks from CMS, we have folks from QuadraMed and other in the industry, to give them the latest interpretation information on what's happening in that area. And we have, earlier in the year, developed a section on our website specific to ICD-10 where hospitals can come in there, post their questions, and we would coordinate submitting those questions to CMS staff whom we have direct contact with, and other experts in the industry get all those questions answered, and then redistribute it back to the members who are participating. We also host a quarterly user group conference call among the hospitals, and this is an effort for them to learn from each other as peer learning, peer sharing. But as part of those calls, we also have experts on to give the latest updates on what's happening in the industry from a policy standpoint as well as implementation. There are tools and resources and services that often we provide a quick overview of so that they know what's available out there in the industry for them to access if they wish. And we also provide them with programmatic updates in terms of what's coming in the near horizon, what's being planned for year two and year three, that way we get feedback from them as well in order for us to make sure we meet their specific requirements.

A little bit about the benefits of the partnership, because I think this is really where it may be useful for those looking at different ways in which such a program can be coordinated elsewhere. So what's unique about this program is that because of the partnership we were able to leverage very significant group discounts, and on top of that, because of the sheer number of hospitals involved in the program, there is an inherent accountability built into the process. Without going into sort of specifics in what kind of discounts we were getting, I can share with you, for example, that through this grant program we're able to leverage rates where for the same amount where essentially we're paying something between 80 or 90% discount on what it would cost each individual facility if they were to go and access the exact same set of services in the market. So what that means is we're able to stretch the grant funding dollars quite a bit ways, at the same time, being able to coordinate a good number of activities with vendors and resources that they couldn't get on their own, or at least it would be more difficult for them to get on their own. So that in and of itself, I think is a great benefit. It provides a community, and also an identity among the hospital participating because now they have the ability to work with each other as well. When we get on those calls, you know they know who the point of contact is for each facility, and there's quite a bit of dialogue and sharing among the facilities, and I think that in itself is a great benefit. The other thing is that obviously since there's no cost to the facility, participation is quite easy. In fact, when we first started the program, or the idea for the program, we were pursuing grant funding for only 25 facilities; and when we got funding, developed the program, released it, immediately we realized that the need for the program is much larger than what the grant funding was able to support. So instead of 25 hospitals participating, we now have 75 hospitals wanting to participate, so we had to go back and for a second round of funding

requests in the hope of trying to get the other 50 in. Then we got the other 50 in, and now we have another 12 or 15 hospitals already on the waiting list wanting to access this level of service. So today we already have 75 hospitals in this program. That's a great group for them to start the process with, learn from each other, and we have a good another 12 or so hospitals waiting to have funding available to support this, and we're in the process of pursuing additional funding in order to do that, not only for the first set of activity but for those that are already in the program to begin planning and supporting activities for year two and year three as we get closer to the compliance date. Of course the other thing is the access to expertise and resources and all the intangibles around the program. You know this is – there are through QuadraMed a number of certified coders, there are educators and trainers, there are assessment experts, and so all these resources become available to the hospitals, some of which are supported through the grant funding, and some of which are additional sort of out scope work, if you will, for -- available for the hospital. But the other benefit is that all the additional services that the hospital may want and pay for are all pre-negotiated at that discount rate. So then no matter what level of service it is or what kind of services they want, the per hour rate for all those services have been pre-negotiated through us so that the hospital will know exactly how much it would cost them if they go forward.

In terms of planning for the next phase, we have already, in the last several months, begun to look at all the various opportunities and activities for year two of this program. And here is by no way, no means is an exhaustive list, but here are some of the key things that we're looking at: Obviously impact assessment, continuation of the readiness assessment with a roadmap and analysis report that comes back is an important piece of -- an important early piece for them to determine where they are in relation to their internal capabilities to comply with that transition come October 1<sup>st</sup>, 2013 date. We're also looking at how we can plan regional onsite training workshops that are taught by certified coders, and that's important because we want to make sure we get closer to the facilities and being able to support their needs. We also are looking at scheduling, on top of that, monthly and bimonthly live ICD-10 webinars. And where we would provide a series of really comprehensive ICD-10 curriculum based type of education, we have evaluated and looked and researched some 20 different modules and 20 different types of topic areas that we think are very important. Tried to put a curriculum around that and be able to support the development of both that curriculum as well as the video content to a hospital. Finally, we're looking at, as we get closer to October '13, is to look at boot camp, deep dive type of training, again with certified coders, but this time at the facility itself. Or have one facility host the event and then surrounding facilities get together in order for them to learn together from that. And then the last approach is – the last two things that we're actually contemplating is, as I mentioned before, we're also doing meaningful use assessments. I'm building meaningful use roadmaps for our hospitals. As this is very much related to that effort, it seems to make sense that while we're onsite, and we spend a good four days onsite for the meaningful use assessment, that we could possibly extend it to another half a day or a day, whatever the needs of the hospitals are to extend that assessment and have a component where it will be sort of the ICD-10 readiness piece as well on top of that. It seems to make sense; it cuts down on the costs, the travel costs. And then finally we're looking very much now into sort of how ICD-10 is related to medical necessities, and chart audits, and how we combine all that under a compliance program and have various different modules and focuses when we're onsite. It turns out the medical necessity for most facilities in terms of observation bed versus in-patient, and how that translates through

reimbursement possibly has a significant impact on the facility, and so we don't want to have all these programs and activity be sort of inside those, and rather to find a way to integrate some of these activities so that when we're onsite we can offer them various different activities that then come together to make sure that the hospital is well prepared.

That's all I have, and I'll be glad to answer any questions you may have. That completes my presentation, and I'd like to turn it over to our next presenter, Ms. Williams.

**Gervean Williams:** Thank you so much. Again, this is Gervean Williams, I'm the Director of Finance and Operations for the National Association of Community Health Centers, and I would like to thank HRSA for this great opportunity to partner with all these great organizations under the very timely topic. Just a little bit about my association, our mission is to give access to all for affordable high quality healthcare across the country. We have several divisions in that. In my division, Training and Technical Assistance, we provide technical assistance to health centers in the areas of governance, growth and development, IT, finance and operations, and emergency management.

Now, what I'm going to kind of talk about today are more of the operational things with ICD-10 implementations, but I want to start off with talking about some of the myths that I kind of hear out in the field. And one of the big ones I hear is it's not going to happen, and as we heard today directly from CMS that, yes, October 2013 it is going to happen so you really need to get prepared for it. Another thing that I hear often is this is an IT thing so my software vendor is going to be responsible for it. And this is bigger than just an -- there is a huge IT component, but it's bigger. It's operational, it's training, and it's education, and it's testing. And then another one is we have plenty of time in order to implement the ICD-10. And I'll go to this next slide to address that myth.

If you look at it right now, a lot of thing should have already been done. Ms. Dant from CMS talked about the 5010 conversion, and what you have to do is get transferred to the 5010 before you can even code in the ICD-10 codes, so really by now you should have been doing all the internal and external testing for the 5010 version of transmitting your claims out electronically. So that should have been done starting back in 2010, so there isn't a lot of time. You know you need to have a plan in place in order to address this huge change in healthcare.

So I'm going to talk about some potential impacts on the implementation of 5010 and ICD-10. One main thing I wanted to talk about is that most other countries and the world already use ICD-10, so by switching to this we'll be able to communicate with them with our disease and our disease management and things like that on a global level. But the three areas I was going to address was the IT, finance, and provider – impact on providers and staff. Okay, first on the IT concerns, the impact on transactions, and I'm just going to focus on the 5010. Now, just to go back, the 5010 is the electronic version of submitting your claims out to your clearinghouse and your third party payer. So the 5010 change will impact all the different, all your healthcare claims, your eligibility inquiries and response, so your enrollment forms, your remittance advice, and your authorization. So just going to 5010, which is due in January of 2012, this January, all those different forms are going to have to be reconfigured in order to be sent out. So that's a huge change in your practice management system and your EMR system.

Then talking about -- going onto your IT staff, and this is your internal IT staff. Your internal IT staff need to know all the implications of this change, and then have the resources and the training in order to talk to your vendors to update your systems, and then to talk to the other staff people to let them know what changes are going to have to occur by January 2012, then other changes by October 2013, and then have your system set up in order to go through with those changes. Then which are electronic medical records, to changing out all your ICD-9 codes into the ICD-10s. Because currently the ICD-10 and you know community health centers, there's about 17,000 different codes in ICD-9. In ICD-10 it's going to be over 150,000 codes. So all that information pertinent to your organization will have to be put into your EMR system, and then also you would have to have some kind of crosswalk between the ICD-9 code sets and the ICD-10 code sets. And I'll talk a little bit more about that when I talk about the UDS report later. Then the same goes for your practice management system. You will have to change your claim form so that it can hold the new ICD-10 codes. Right now, under the ICD-9, it goes between three to five characters and ICD-10 you can code from three to seven. So in your 1500 form, you have to make sure that it can hold up to seven codes with ICD-10 and successfully transmit not only through your clearinghouse but all the way through to CMS or any of your third party payers. So those are just barely touching on some of the huge IT concerns going from 5010 and to ICD-10.

So now the finance concerns, and they are many. I know CMS is spending tens of millions of dollars in implementing this, and you and your organization will have to do some investments to this implementation also. So you should have a budget for the implementation of ICD-10, and what should you include in that budget? Software, hardware, you might need to buy new hardware in order to make sure you can run, you have an engine that can run all these codes through. And then software upgrades to make sure that you have the latest and greatest versions of whatever practice management or EMR system so that they can transmit and hold all those codes. And then also testing; as I mentioned before, the version 5010 is due to be in use in January '12, January 1<sup>st</sup> of 2012, so you need to be testing that you can send claims out from your system to the clearinghouse to your third party payer, and vice versa, internal and external testing. So you'll have to budget for that because that's resources that you'll have to take for your day-to-day operations to prepare you for the future. Then you have to budget for training, and this is training on all different levels; how much time, how much money that you're going to dedicate to training your staff internally and externally. Then I had this comment down here, "Will you be able to send your claims out electronically?" You know there are some third party payers that they don't even accept paper claims, and if you're not ready with version 5010 and ICD-10, you may not be able to send your claims out electronically, so then you may need to budget for a cash flow disruption. Because if you're not sending your claims out, you're not going to be able to get cash in, and vice versa, if you have a third party vendor that they're not set up to go on with the transition, and that might impact you, and that's going to impact your cash flow also. So budgeting for a reserve, a just in case scenario, because you got everything planned, but then there could be other layers in the process that they may not be prepared, and they can impact your bottom line and your cash flow. So those are a couple of the finance budget considerations.

Then impact on provider and staff. Training, who should you train? And really this is pretty much like an all hands on deck. You have your providers, your clinic staff, your billing and your finance. Now what kind of training will depend on their individual roles and when you're going to train them. And I would like to add in IT, your IT staff should already be up to speed on the implications of ICD-9 and version 5010, and training them on how to implement that. Your providers, maybe you want to push that down a little bit later to update them on all the different coding and giving them skills and the tools and everything to code in ICD-10. Then your clinic staff, who supports your providers, and the billing and the finance know what to expect, what changes are going to be on reporting, what changes are going to be in a claim processing, and things they should need to look out for. Then when should you train? Well, you should be training now and do a phased approach. Do maybe an inform now, inform now with your providers, and then when you get closer to 2013 do like weekly updates on these are the new codes, let's do a drill or do some kind of provider training. But kind of phase it in where you do that heavy provider code training when you get closer to the go live date. But so far as your IT and your billing and finance staff, they can be getting trained today on how to look at different reports and what impact is this going to have after 2013 from now. And then how much training? It all depends on the roles and the responsibilities. Of course your providers are going to be, it's going to be a huge training thing for them, so you would have to look to see how much you need for each person. I know I looked at a couple of different stats from like the American Medical Association, and they're saying between 20 and 80 hours between providers and billing staff. That's just like a ballpark figure out there, but you really would need to look at your organization and your needs and see what you need to do in order to make sure that you can successfully implement the ICD-9 and the 5010 conversion.

Okay, then on planning needs, what first you need to do is assess your current system. See what you have, see what you can do, and then identify your internal and your external team. What I mean by that is, first, your internal team, which would be your IT, your Medical Director, your finance department, your nursing staff, get that team lead to get together to sit down to discuss all the things you need to consider so far as changing your templates, changing your claim forms, and doing all those things. And have a team approach because you want to make sure everyone is there so you are going to get all aspects of it. Then your external team, this will be your clearinghouse, your third party payers, definitely use the CMS website will all their information and a resource to reach out if you need some help on that, and identify the people that you're going to work with in order to go through this transition. And one thing I would definitely say everyone needs to do is contact your IT vendor or your clearinghouse vendor, and ask them what is their plan on converting from 5010 and ICD-10, and let them see – let you see in writing, their plans in order to be compliant. Because if you do everything internally and if they don't do what they need to do, then you're going to be stuck, and you're not going to be able to get your claims out, and you'll have that cash flow disruption. And when you're talking with your IT vendors, if they say they're going to go ahead and do it, get it in writing that they're going to do it; and if they're going to charge you, get it in writing how much they're going to charge you. Because the last thing you want is for January 2012 to come up and your IT vendor say, "Yeah, we can do it for you, but it's going to cost you X, Y, Z, dollars," and you have no idea. So talk to them now and get it in writing how much it's going to cost for you to do this transition. And another thing on the planning needs is implement a timeline. What I did here in MAC is I did kind of like a countdown. I started at what I need at October 2013 and backed into what I need to do in order to

lead up to that, so, maybe do the same thing with your organization. Then I would definitely say train, test, train, test, and train again. You definitely need to test and make sure, you know do the worst case scenario, because if you test it in the prime circumstances, that's not going to be the true day-to-day testing, but test on a worst case scenario. Test if you have to do a backup server. You know test all the different things, and then test with your staff, do the train to trainer so there's not just one person that knows all of the details on the transition and have all the resources. So I can't say enough to test and train completely throughout your organization, and then refresh. And maybe stick up little notes on this current ICD-10 fact. For instance, did you know that they have a code in ICD-10 for bizarre personal appearance? That code is R46.1. To add some humor to it, but to get the buy in from your staff and everything so they can be onboard in helping you through this transition.

Now I'm going to talk about how this ICD-10, 5010 impact, can directly impact community health centers. And just in case some people on the phone don't know, community health centers are – they get 330 grant funds from HRSA in order to provide care for the underserved and uninsured. And by giving that 330 fund, they get different reimbursement under Medicare and Medicaid, and because of that they bill differently. Community health centers can bill all parts of Medicare. They can bill Medicare Part A as an institutional provider, they can bill Medicare Part B as a carve out fee for service; they can bill Medicare Part C and Medicare Part D. So community health centers, they bill on a UBO4 and a 1500, so they're going to have to look at this transition for both forms in all four different formats. So this is a very administratively intensive situation that they'll have to look at all the components and make sure that their system is set up in order to handle this. Another thing the community health centers, since they do receive 330 grant fund, it means they have a report called the Uniform Data System Report that's do every year. And there are several different tables on it, but one table I wanted to mention on this webinar today is Table 6 on the forum, and it's a diagnosis and service rendered, where the health centers have to report on the patient that they served and different diagnosis. For instance, if they have hepatitis C they have to report on hepatitis C, asthma, chronic bronchitis. So in this report, they have to have the number of visits by diagnosis codes, the number of patients they served. So with this change, and since the change is going to be in October 2013, in the year 2013, they're going to have to have a crosswalk between the ICD-9 codes and the ICD-10 codes so that they can report on that whole year of all the patients that they've seen. So you'll have to sit down with your medical director and your UDS preparer to say, "Okay, this is what we're reporting on the ICD-9, how does this translate into ICD-10?" So this is a huge report the health centers have to do every year, and this is going to be a very detailed table that they're going to have to spend a lot of time to make sure they capture all the data accurately. Then another thing in community health centers, and probably in other organizations for grant writers, I know a lot of grant applications, they ask what are your outcomes you're going to look for, what are you trying to treat; what are you trying to improve upon? So you're going to have to do that crosswalk again in grant writing in saying looking at ICD-9 and how that translates to ICD-10, and incorporating that into your grants in your submissions out to your grantors and to HRSA also. So that's how it definitely impacts the community health centers a little bit different than other organizations. But that just reinforces the fact that they need to definitely plan to address all these different issues, especially with the billing and helping us having to bill on the UBO4, the institutional form, and the 1500, the primary care Medicare Part B form. So that's very huge.

Now, on the next -- a couple of resources, we've been doing training sessions at our national conferences for the last two years under ICD-10. Coming up, actually I didn't put on the slide, most recently we have a financial operation management IT conference this November 14<sup>th</sup> through 16<sup>th</sup>, and at that conference we're going to have breakout user groups of health centers. So health centers who use the same software and hardware are going to have breakout sessions so they can discuss things, and ICD-10 is going to be one of the things they discuss. So what are you doing, this is what we're doing, can we use the resources and join resources? And then what I have on here, we're having an ICD-10 webinar on February 23<sup>rd</sup> and have the link there for the webinar. And then also coming up in 2012, we're going to develop an ICD-10 toolkit. It's like a readiness toolkit on things you need to look at. And then also we'll have more educational sessions at our national conferences. And also I put on here, one of the great -- CMS had so many great resources, I say definitely look at the CMS website for all their resources because that's what we use, and with a combination with other organizations, but CMS has great resources out there.

And just acknowledgement, when I put this together I used a lot of information from the CMS website and the ICD Planning Tool, and information from PMG Incorporation for a lot of the stuff about the ICD-10.

So once again, just train, test, and just try to think outside the box on all the different things that can be impacted by this transition, and then reach out for help and assistance because there's tons of help and assistance out there. And that concludes my presentation. I will go ahead and turn it over to Dr. Freeman.

**Dr. Victor Freeman:** Thank you, Ms. Williams. I want to go through my presentation fairly quickly because we do want to get to a lot of the questions that have come forward. So I want to get right to the heart of the matter here. When it comes to this ICD-10 transition, I want people to remember that this really is an opportunity, and that the major goal is to do successful change management. Now, this has been my favorite model for change management, and you may have another approach to it, but essentially making sure that people are aware, motivated, knowledgeable, skillful, and that they're getting some sort of reinforcement is really going to be critical to making this whole process work. I think one of the things that we are doing here at HRSA is we've set up a website, it's already up right now for you to go to that attaches to a lot of the CMS resources, but we've organized a lot of that information for you at our current website. We want you to know that you're not alone; HRSA is definitely here to help. But some of the things that are going to be critical from an awareness point of view are remember what the deadlines are. You heard from Ms. Dant at CMS, the deadlines will not be moving, so do not count on that. On the slide it says January 1<sup>st</sup>, 2012, HIPAA, it should be 5010 in there, so 5010 is what you want to remember for January 1<sup>st</sup>. But also, pharmacy code standards are going to be changing. 3.0 is the typical pharmacy transaction code, D.0 is what Medicare Part D uses. If you have a pharmacy within your community health center, if you have partner pharmacies, you need to check with them, or on the 340B program to make sure that they are on the ball in terms of upgrading their standards to be able to make those adjustments for January 1<sup>st</sup>, 2012.

It's important that people recognize that we are less than 100 days to the end of the year. It is exactly 100 days until Monday, January 2<sup>nd</sup>, when many of your clinics will reopen. That's

coming a lot faster than you think. In terms of awareness, we've shown you one of the documents here that is on the CMS website. These slides will be available on the HRSA website. We will also make a list of the slides that are referenced of the websites that are referenced here so that you can go to these sites and look at these documents. This is a CMS two pager, I've been through it; I recommend it for presentation to your senior leadership, to your governing boards. It is very simple and basic. It explains the why of the conversion, what's happening with the conversion, and gives you compliance next steps.

Next slide are also some useful and simple materials. These are four pagers. On the left you've got what I think is a very good guide for giving to your clinical staff. It is very useful to share with your quality improvement staff, frontline staff. It goes into much more detail about ICD-10 conversion, but you probably want to start with the document on the right because that goes in more detail to the 5010, the D.0, and the 3.0 conversions that are pressing for January 1<sup>st</sup>.

Remember that if you fail to do this, or fail to do this well, you're going to run into lots of problems that are going to be hard to recover from. So it's best that we do everything we can to do successful change in management so that you can avoid losing any billing revenues, so you can avoid government sanctions, but change management is going to be key to avoid disruptions in you care delivery, to avoid demoralizing your staff, and to avoid losing some staff who may be overwhelmed by the whole process.

When it comes to knowledge, there is a lot of useful information out there. What we've identified on the left there is the Get Ready 5010 site. You'll see all the sponsors of it in the bottom right of the little graphic there, and there are four free webinars on that site. Those four free webinars are about 80 minutes apiece, so there's a lot of detailed information in that. If that's a little too much for you to start off with, you can go to the AMA webinar that's on the right, it's only 32 minutes and it's a good introduction to what's going on with 5010 and the ICD-10.

When it comes to skills, you will find there is some detailed checklist out there. This one from the CMS website here, its five pages long so it's very detailed. If that's too much, too overwhelming to start with, the AMA has on that's only two pages long. So there are resources that are there to help you begin the planning and budgeting that you heard from Ms. Williams.

Last but not least, you do want to be working on the reinforcement end of things. Why go through this alone? Why not do what Mr. Ngo talked about with the TORCH group? Have a users group, peer clinical practices. Begin to support each other, share tools, and share strategies. We at HRSA will be setting up a lot of technical assistance for you, and we'll be doing that in collaboration with the Office of Rural Health, the Bureau of Primary Healthcare, and obviously here at the Office of Health Information Technology and Quality. You already heard a great presentation from NACH, and you know the resources they're going to be putting out. There are health center controlled networks that are out there, primary care associations, and there's probably some state and local resources that you can also tap into.

It's important to recognize that the only constant in the world is change, and the real issue is how are you going to manage it? We hope this has been helpful, and one highlighting the importance of preparing, but also letting you know about some of the resources that are available to support you.

At this point, I'm going to turn it over to our crew to help us in answering some of the questions that have come through.

**Mary Washington:** Thank you so much, Dr. Freeman. I'd like to invite everyone to fill out the exit poll that should be popping up on your screen momentarily. HRSA will use your feedback on this poll to improve and decide on future topics for the webinars, so we do sincerely appreciate you taking the time to fill this out.

We will now begin the question-and-answer session. I want to remind all of our participants to send in your questions using the chat feature on your screen if you haven't already done so. And to all of our presenters, feel free to chime in on each of the questions if you have anything you'd like to add. Also, the materials from today's webinar will be posted to the HRSA Health IT website within the next two to three weeks.

Okay, so there were several questions that came through on the chat, and I'm just going to pick and choose as many as I can. And the first question I want to pose to Ms. Dant. **Can you speak to how dentists and dental coding will be affected by 5010 and ICD-10 and compliance?**

**Christi Dant:** Generally the ADA coding is untouched in this, and I'm no expert on that, on the overlap. But to the degree if there's any surgical procedures that would be medically warranted, then that ICD-10 coding would be required, but there has been no coding -- no code change for ADA.

**Mary Washington:** Thank you. Does anyone else want to add to that? Okay, the next question is for Quang. **A lot of the audience members seem very interested in the simulator and resource tools that you mentioned during your presentation, is there anything similar to this for small rural practices or home health agencies, can they access the tool?**

**Quang Ngo:** Yeah, actually when we were developing the specifics to the deliverables to all members, its set up in a way now that I think could be successful, and we can provide this really to anyone that's interested. So we could go back to QuadraMed and basically negotiate the same type of rates and the same type of, you know, basically extend the services that are available to our members to anyone, to any group who may be interested. As I mentioned, I didn't go into the specifics in terms of amounts, but I can tell you that we spend a great number of months really negotiating those discounts and benefits down, that this is many times more beneficial or savings than you would get if you just go to them straight. So we can offer that for those who may be interested, either maybe we can follow up and either we can do a conference call to make sure we meet, we understand your needs, meet your needs, and then look at the best way in which we can help either through coronation or through extending the program to anyone who may find it useful.

**Mary Washington:** Thank you so much, Quang. The next question I want to post to Dr. Freeman. **Are you aware of any grants or special funding opportunities for HRSA grantees to assist them with the transition from ICD-9 to ICD-10?**

**Dr. Victor Freeman:** I'm not aware of any specific funds that have been set aside for that purpose. Most of the funding that I'm aware of has been put into supporting technical assistance.

**Mary Washington:** Thank you so much, Dr. Freeman. So the next question, Ms. Dant, **a lot of our audience members are very interested in learning more about this CMS Artifacts site that you mentioned, can you please repeat the name of the website, the URL for the website?**

**Christi Dant:** Unfortunately that one is a whole lot easier to post somewhere.

**Mary Washington:** Okay.

**Christi Dant:** Because it's buried, and it's hard to find and describe. And what I will do is make sure that I send out a link and we'll be able to post that. I would encourage people, it might be better to wait for the small provider handbook; it's probably much more suitable to your use. The Artifacts link is basically the one -- are the documents that we used in our own internal project management office, and so they may be much better suited to very large scale conversions. So it might be a little more cumbersome than helpful, but I will happily provide that (inaudible) link.

**Mary Washington:** Okay, thank you, Ms. Dant. If you could send that to us, we'll make sure we include that in the question-and-answer document. **Speaking about the booklet, can anyone tell us when the book will be available?**

**Christi Dant:** Its past due. It's been written, we're working through clearance at CMS, and it's taking a little bit longer than we anticipated, but I was told it would be available this month.

**Mary Washington:** Okay, thank you. All right, so our next question, I just want to open the floor to all of our presenters. **Will skilled nursing facilities and long-term care facilities be required to have certified coders for ICD, for the ICD-10 conversion?**

**Christi Dant:** I don't have enough knowledge of the individual CMS programs to be able to respond to that. If you need certified coders now, you'll need them afterwards. If it's not a requirement, it seems unlikely that that will be added, but you will need to use the codes.

**Mary Washington:** Thank you. Okay, so our next question I just want to pose to all of our presenters. **A lot of our audience members are asking if there is a resource that provides them with a timeline of ICD-10 implementation tests that they can use for guidance.**

**Dr. Victor Freeman:** Well, I did present some when I was going through my slides. So if you go to the CMS website, there are multiple documents that are PDFs that will give you that timeline. We are identifying additional resources that will also do that through the AMA, and also the American Academy of Family Practice, Family Physicians.

**Mary Washington:** Thank you so much.

**Gervean Williams:** This is Gervean from NACH; we will develop a readiness tool first quarter of next year that will be on our website.

**Christi Dant:** Additionally, CMS just developed a widget that's going out to a lot of the associations, and we'll make sure HRSA has it to post to their website, and it is exactly that what you're seeking.

**Mary Washington:** Thank you. **So, our next question asks, will there be websites for pharmacies or billers to find or obtain ICD-10 codes?** Can anyone respond to that question?

**Gervean Williams:** Well, the World Health Organization, they have like an ICD where you can just go look up codes, if that's what they're looking just for all the codes, it is out on the website. And if they look -- Google WHO.

**Mary Washington:** Thank you so much, Ms. Williams.

**Christi Dant:** CMS also has the codes posted.

**Mary Washington:** Thank you. **Okay, so our next question asks how will ICD-10 impact DME suppliers?**

**Christi Dant:** Again, that gets into some of the technical aspects of CMS programs that I'm not terribly aware. If you use ICD-9 codes at all in your transactions, you'll need to use ICD-10 codes after October 1<sup>st</sup>, 2013.

**Mary Washington:** Thank you. So our next question is for HRSA. **What is HRSA's plan to support ICD-10 non compliant providers after the October 1<sup>st</sup>, 2013 deadline? Will ICD-9 claims be accepted after September 30 of 2013, if so, under what conditions?**

**Dr. Victor Freeman:** Well, first of all, I'm not aware that HRSA actually accepts claims, that's really CMS, but we don't anticipate that anyone is going to be in non compliant. We are here to support 100% compliance.

**Mary Washington:** Thank you, Dr. Freeman.

**Christi Dant:** And I do have to weigh in that organizations will need to be able to be able to dual process until all of the -- because ICD-10 is related to dates of services, which means if you have someone who's hospitalized from April 1<sup>st</sup> to September 30<sup>th</sup>, that's fine, but if they cross into October 1<sup>st</sup>, or October 31<sup>st</sup>, you'll need to use ICD-10, so that's one of the challenges is that it's dates of services rendered. So when you're compiling, if you're back billing or refilling a claim, anything before the cut-off we'll have to use the 9 codes, even though you send the bill afterwards, it is the date of service.

**Mary Washington:** Thank you. **So, some of our audience members were asking for advice on what they should do if their clearinghouse is not prepared for HIPAA 5010 compliance? Can anyone respond to this question?**

**Gervean Williams:** This is Gervean from NACH. I would say you would definitely have a serious conversation with them, and if that's your only clearinghouse you might want to seek out maybe legal counsel, because if they're not prepared, you're not going to be able to get your claims out and you won't get paid. So this is something that you definitely need to get something in writing on how a plan b, or what's going – what you can do until they get compliant.

**Christi Dant:** I would concur with that.

**Mary Washington:** Thank you. **So, our next question asks, how much ICD-10 training and 5010 compliance training is projected to be needed for Medicare Certified Home Care Agencies?**

**Christi Dant:** I sound like a broken record here. CMS is such a large organization with so many funding streams it's really difficult for me to know, but that's something when we get those kinds of questions, we'd be happy to try to get those answers to you. It depends upon the level of coding. Again, those not using procedure codes will have less of an onerous task than those just using the diagnosis codes. So the training, intensive training for diagnosis coding is about 16 hours. If you're doing both, it gets much, much higher.

**Mary Washington:** Thank you, Ms. Dant. **And to add onto that, are you aware if CMS offers any webinars for learning ICD-10 specific to individual coders?**

**Christi Dant:** We do have on our website a presentation by AAPC that would be very good for folks to take a look at. We are not going to be hosting training for individual coders, to my knowledge, simply because it would overwhelm any resources that we have. But, that's a great place to start taking a look at that session.

**Dr. Victor Freeman:** Yes, I think the AAPC, as well as AHIMA, A-H-I-M-A, have been doing trainings for individuals, and they've been moving those around the country, so I think there lots of resources that are out there right now for training coders.

**Mary Washington:** Thank you. So this – the next question is very interesting. **It says, “I am a small provider, a dietician and diabetes educator, do you anticipate that part of the small provider handbook will address my professional unique requirements?”** So this is referring to the ICD-10 booklet that I believe CMS plans to distribute in the next month.

**Christi Dant:** That's hard to answer not knowing what the practice looks like and what types of software are involved. It will be very comprehensive, and if it doesn't fit, don't use it is about all I can suggest.

**Mary Washington:** Okay.

**Christi Dant:** There might be extra steps or functionalities that aren't applicable to that particular practice.

**Dr. Victor Freeman:** And I would go to your professional organization. I'm sure there must be an American Association of Diabetes Educators, they should be developing tools and toolkits and support for their members.

**Mary Washington:** Thank you. **Okay, our next question asks how ICD-10 conversion and 5010 compliance will affect small providers who file paper claims?**

**Christi Dant:** They provide...

**Dr. Victor Freeman:** Well this.... Okay, this is Victor Freeman; we had an interesting set of slides. The AFP developed a sample super bill for a family practice. And they showed in ICD-9 it was basically two pages. Many of you may call it a billing sheet, but on one side you've got the patients name, the procedure you use, the bottom you got the diagnosis, and on the back you've got all the potential diagnosis that typically come up in their practice and the codes that go with them. They then use the CMS tool to convert that into ICD-10. The list of diagnostic codes went to nine pages. Now, you don't need to have it go to nine pages. If you sit your clinical staff down with your financial staff, with your billing staff, and talk about one of the most common diagnosis, you can develop billing sheets that are much more compact, and that respond to what your practice is like and what the business rules are with the payers in your area, and have a process that will work very effectively for you if you're using billing sheets.

**Mary Washington:** Thank you.

**Christi Dant:** I would like to just mention quickly, there is a thing called GEMS, General Equivalency Mapping that is also posted at the CMS website. But you need to know there is not a technology only fix, the codes do not convert one-to-one, there does – there is a certain level of one-to-one, but then it will take human intervention to take that final step. So paper claims will still be processed by some entities, that's where you need to review your own contracts. Some of the insurers may not accept them. I would caution against thinking that you can live in both worlds, and I think it's important for everybody to just bite the bullet and make the jump, because trying to manage, well; I can file 9 codes here and 10 there. Additionally, 5010 is a platform not only for claims, but also for all of the other electronic transactions for inquiries. So again, you would then have to relate, stop using electronic transactions, and use all manual or phone. So I think it would be very labor intensive and cumbersome, and it would be much wiser to direct resources to full compliance.

**Mary Washington:** Thank you. **So, the next question, one of our audience members just wanted a brief overview as to why we're switching from ICD-9 to ICD-10 conversion, what are the improvements that are being made by doing this?**

**Dr. Victor Freeman:** This is Victor, let me just speak from a point of view of a clinician, but also someone who has done a lot of work in quality improvement. The ICD-9 system is 30 years

old, I mean it's antiquated. It no longer has all the terminology we need to keep up with practice and it's not designed to really expand to include a lot of the new procedures and diagnosis that we need to use now. So it is an antiquated system. Other countries have been using it since the 90's, in the last decade Canada switched over, so we're one of the last ones to really come up-to-date. We need the level of detail that exists in ICD-10 in order to really track what's happening to patients. So it is essential that we move forward.

**Gerveen Williams:** And Dr. Freeman, this is Gerveen from NACH, and doesn't it help us communicate when, just like when the H1N1 a couple of years ago, we can more easily communicate with other countries to track that kind of thing?

**Dr. Victor Freeman:** Yes, it does put us in the same platform in terms of comparing what's happening with our patient populations.

**Mary Washington:** Thank you so much. **So, our next question, I just want to open up to all of our presenters, we're talking a lot about ICD-10, but someone wanted to know about DRGs and how with the NDC – will NDC be the same weights?** Can anyone speak to that?

**Christi Dant:** I can on a very high level; this is Christi Dant with CMS. There's going to be a code set freeze in October to allow everyone to make the transition. We don't want to keep moving the codes, even though we do realize there'll be some corrections and improvements to ICD-10. And it's those codes that really inform the DRGs. Again, on the CMS website there is the example of our conversion of the DRGs from ICD-9 to 10, is our first kind of big test of large conversion. The intent is to wait until we have two years worth of ICD-10 data before we would make changes to the DRG groupings. I hope that answers the question.

**Mary Washington:** Thank you, Ms. Dant. And I think we have time for maybe one or two more questions. **How does – how will ICD-10 and 5010 impact Department of Health for each state?**

**Dr. Victor Freeman:** I guess a lot of it is going to depend on whether or not those state health departments use ICD-9 or ultimately ICD-10 codes, or whether or not they are on another system called SNOMED. So if they use ICD-9, obviously they'll have to convert to ICD-10. Also, if the state health departments have clinical facilities that do engage in billing that use ICD-9 obviously they'll have to convert to ICD-10, and also the 5010 transactions. Also, if they have any pharmacy services that they render to members of their state, they will also have to do the D.0 and 3.0 conversions, along with the HIPAA 5010 upgrades.

**Mary Washington:** Thank you so much, Dr. Freeman. **And our last question, one of our audience members stated that they've heard that workers comp won't be prepared for ICD-10 and will still want to receive ICD-9 claims.** Can you -- can we -- can anyone comment on that?

**Christi Dant:** Yeah, it is correct our workers comp is not a HIPAA covered entity. There are several entities that are not HIPAA covered. Many of them, we have heard antidotally, are going

to make the shift because they will be receiving ICD-10 codes. So to the extent that each state kind of has its own idiosyncrasies it's hard to give a uniform reply to whether or not they'll accept or compel ICD-9, but I would think they'd be on thin ice demanding an ICD-9 code.

**Mary Washington:** Thank you so much, Ms. Dant. So I believe we're out of time. That wraps up today's webinar. I do want to make all of our participants aware that we will be developing a question-and-answer document that will be posted on the HRSA Health IT website. I want to thank each of the presenters for taking the time to participate, as well as all of our viewers and listeners out there. We look forward to meeting with all of you again at the next webinar. Thank you, and have a good weekend.