

## **ICD-10 Tips for RHCs**

Rural Health Clinic Technical Assistance Series Call

May 5, 2015, 2:00 pm ET

**Coordinator:** Ladies and gentlemen, thank you for standing by. For the duration of today's call, all participants will be on a listen-only mode. During the question-and-answer session if you would like to ask a question, please press star 1 on your touch-tone phone.

Today's call is being recorded. Should you have any objections, you may disconnect at this time. I would now like to hand your call over to Mr. Bill Finerfrock. Mr. Finerfrock, you may begin.

**Bill Finerfrock:** Thank you operator and thanks everyone for participating in today's call. I want to welcome everyone. My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call.

Today's topic is ICD 10 recap implementation tips for RHCs and our speaker is Patty Harper. Patty's the CEO of INQUISEEK, a company that does a lot of training and consulting in education. She is a certified ICD 10 trainer, has spoken at several NRHC meetings and is a well-respected individual particularly as it relates to ICD 10.

Just by way of background in terms of the series for those of you who may not be familiar, the series is sponsored by the Health Resources and Services Administration Federal Office of Rural Health Policy in conjunction with the National Organization of State Offices of Rural and the National Association of Rural Health Clinics.

The purpose of this series is to provide RHC staff with valuable technical assistance and RHC-specific information. Today's call is the 64th in the series which began in 2004. During that time over 16,000 combined participants have participated in these teleconference calls.

As you know there's no charge to participate in this series and we encourage you to refer others who might benefit from this information to sign-up to receive announcements regarding dates, topics and speaker presentations at - let me give you a Web address - [www.hrsa.gov/ruralhealth/policy/confcall/index.html](http://www.hrsa.gov/ruralhealth/policy/confcall/index.html).

We will have a Q&A period and we request that callers please provide their name, city and the state that you're calling from. We're very excited to have Patty here to talk about ICD 10. This is a very relevant topic. There's been some a lot about this in the news. Some people are still questioning whether or not we're going to move ahead with ICD 10 at the federal level.

We see no indication to suggest that there will be any further delays in the ICD 10 implementation date which is October 1 of 2015. If you haven't started getting ready, you should. You have a lot to catch-up on.

Patty's going to be I think very helpful today in making sure you're doing the things you need to be doing to get ready so without further delay, Patty we appreciate your taking the time out of your busy schedule to talk to our rural health clinics community here today and look forward to hearing what you have to say.

Patty Harper: Thank you, Bill. It's really a pleasure to be on the call and I think there's about 200 of us on the call and I wish I could look out and see each one of you but we're going to go through the handout so we're going to talk about four basic things that are going to be relevant to ICD 10 implementation.

We're going to do a very brief recap on what is ICD 10. We're going to prepare the ICD 10 and ICD 9 codes. We're going to try to understand a little bit on how we assign the codes or how we actually are going to use the codes in our practices and then we're going to go into some implementation tips.

There's a lot of material in your handout. We're not going to go over every single slide but they're there for your information so we're going to start on Slide 3, Page 3 and what I want us to see is the worldwide implementation of ICD 10 and like Bill said we've had a number of delays and we're all hopeful that this year will be the year that we implement.

We are a little bit behind the rest of the world in implementing ICD 10 and I think the map with the graphic for that on Page 4. When we talk about ICD 10 and we'll be on Slide 5 now, the codes that actually originate with the World Health Organization and ICD 10 is the 10th edition of that code set and actually ICD 11 is due to be released this year.

Now it takes several years for the code set once it's released to be adapted in the United States and the NCHS is the agency that does that. They're kind of a first cousin into CMS and to the CDC so it takes us a while.

It doesn't take as long as it has taken us but it does take a while and then you may remember the 50.10 conversion that we went through, the Version 50.10 was a precursor to ICD 10 to make sure that our systems could transmit the codes.

So a little bit of ICD 10 humor is on Slide 6.

We've had a number of delays, kind of wanted to throw in something light-hearted in there and also on Slide 7 is a little timeline of the history of ICD 10 in the United States. Again that's there for your reference. So the big question that we are often asked is why ICD 10? What is wrong with ICD 9?

Why do we need a different code set and the simple truth is is that we're running out of codes. ICD 9 is not expandable in its current format. We've used every combination of characters to come-up with the maximum amount of codes and it's really not accurate to reflect current terminology or current practice or current epidemiology, any of those things.

Our ICD 9 codes really just don't do us justice in that regard and also since we are one of the last countries, since we are the last G-7 country, to adopt ICD 10, our healthcare statistics are not as easily comparable worldwide and we all know that we live in a global economy, global marketplace now.

So if you'll go advance on to Slide 9, Page 9 we need to talk about there are two code sets in ICD 10. ICD 10 CM is the code set for the diagnosis coding. This code set will be used by all HIPAA entities. It'll be used in all environments as payer, inpatient, outpatient, all of our providers and organizations will use the ICD 10 CM code set.

There is a second code set related to ICD 10 and that is ICD 10 PCS and we are not going to go into detail on PCS today but I want you to be aware of it. This will be used to report inpatient procedures only and if you'll advance on to Slide 10, we have just a real simple timeline that we will use ICD 9 until October 1, 2015 for dates of service or discharge date and then beginning with October 1, 2015 we will begin reporting the ICD 10 codes.

So it will be based on date of service or discharge date and on Slide 11 if you'll turn the page, just a simple chart to tell you which code sets will be used in which environments and what the effective date for the use of those code sets are.

We anticipate that we will need to use dual coding for at least the next two years as far as being able to adjudicate claims and go through the appeals and denial processes related with the services provided before 10/1/2015.

So just kind of a little background, where we get the codes, when we're going to start using the codes and why we need a new code set and I hope that the slides in this section will be helpful for you in recapping that. I want to go into a little bit more detail at looking at the ICD 10 CM codes. Again the CM codes are the diagnosis codes.

They're the codes that we're going to use in our rural health clinics to report our diagnosis to our payers and so we should be on Slide 12, Page 12. We're going to talk about the major things about ICD 10 are that there are more chapters in the code set. There are more codes in the code set and there is a lot more specificity in the code set so keep that in mind as we go forward.

So when we talk about more chapters in the code set and we're on Page 13, the codes are organized into 21 chapters. In ICD 9 we only have 17 chapters. The chapter organization in 10 makes a lot of sense to me. It's broken-out some diagnoses into subchapters and I think that you'll find that very helpful.

The chapters have been reorganized like I said to give some body systems a little bit more sub classifications and within the code chapters our inquiries now are organized by site and then the type of injury which I find this to be much more helpful than the type of injury and then the site of the injury. If we move on to Slide 14, 14 and 15 are going to give you the chapters that are in ICD 10.

Now sometimes when I show this chart people say oh my goodness, there's E codes and there's V codes in ICD 10 and we already have E codes and V codes in ICD 9 and that is true but we don't actually have the same exact code combinations or code formats and we're going to talk about that a little bit later so that's how our 21 chapters are organized in ICD 10.

Also our chapters are organized, and this is very helpful to me, the chapters are organized head to toe and then within chapters they're also basically organized within from head to toe and you'll see on this next slide that a lot of use of medical terminology that relates to the location of injuries or illnesses and you might want to hang on to that slide for when we talk about the increased specificities.

Now on Page 17 I mentioned we're going to have more codes in 10. We are actually going to have about five times as many codes in 10 as we have in 9 right now so we go from about 14,000 codes in 9 to almost 70,000 codes in 10 so it doesn't take very long to realize that we're not going to have a one-to-one correlation between the 9 and 10 codes.

And this is going to be one of our biggest challenges as we get our clinics and our processes acclimated to ICD 10 is realizing that we don't have a one-to-one correlation of the code sets. Also when we talk about ICD 10, we have a completely different code format and structure and I'm going to advance on to the next slide.

And on the left you will see how our ICD 9 codes are currently formatted and on the right side of that illustration or diagram, it's how our ICD 10 codes are formatted so we know there are ICD 9 codes currently on five a maximum of five character positions in lanes, three to five and we'll have a decimal after the third character.

In ICD 10 it's possible for us to have seven characters. There is still a decimal after the third character but we have something new in ICD 10 called placeholders. Now placeholders are used in case we need that seven-character extension and we don't have other characters in the fourth, fifth or sixth slots so the codes are much longer.

If you'll turn the page, we're going to just to a really quick comparison of some codes that may be familiar to you dealing with hypertension, common injuries, diabetes and a delivery, an uncomplicated delivery so we see our ICD 9 codes for that and we see our ICD 10 code as well.

On the second row is an example of where we have a seventh character at the end of the code and we have placeholders in the fifth and sixth slots so that's just a quick comparison. Just a visual differences between the ICD 9 and ICD 10 codes are going to that's going to be part of our learning curve is just visually not being familiar with the format of the codes and the appearance of those codes at first.

If we move on to Slide 21 this is basically the same information in a little bit different format. It's going to view the character of the code in 9 and in 10 and the characteristics of that digit or character.

In ICD 10 we're going to call these characters instead of digits so where we're used to saying fifth digit in 9, now we're going to have to say seventh character in 10 so it's just a little bit different terminology there.

If we'll go on to Slide 22, also in ICD 10 we have a lot more specificity in the code assignment and that's a pretty logical thing for us to know since we're going to five times as many codes, we have to know that it's increased specificity, that it's giving us the extra - all the codes - sorry about that.

So and we've already talked about the codes are not a one-to-one correlation between 9 and 10 because there are so many more codes. We'll go on to this slide on 23; it's going to give us a little bit of a go-to reference for our seventh-character extensions.

Our seventh-character extensions are going to deal mainly with injury and fractures and they're going to tell us more about the episode of care for an injury so you may want to hang on to that slide. We're not going to go into detail on it so when we talk about increased specificity so how does that translate to the codes into more codes?

We've never had laterality in our diagnosis codes before. We've had laterality in some of our modifiers for our CPT codes but we've not had them in our diagnosis codes and in ICD 10 if we can capture left, right, unilateral, bilateral, we are now capturing that detail in the diagnosis code.

Also we are going to be capturing the cause or the organism relating to a particular disease or disorder so we are going to be capturing the etiology of this diagnosis in the code.

For injuries and for orthopedics and cardiovascular, we're going to drill down and be much more specific about the anatomical site that is related to our diagnosis. Also we're going to capture characteristics and manifestations of the disease within our diagnosis in a way that has not been done before.

The same thing with complications. And sometimes in ICD 10 where we would have used two codes in 9, we are going to have a combination code in 10 and we're going to try to pull some of that information altogether in one code in the use of a combination code but I'll look at some examples in increased specificity if you'll advance to the next page.

And here are just a couple of examples of ICD 10 CM look and how detailed, how specific the descriptions on those diagnosis codes. If you'll advance to the next slide, we're also going to look at some examples of ICD 10 codes and where the complications or the severity of illness are now in our diagnostics statement.

So you can see that we do have quite a bit more specificity and that's what accounts for the increased number of codes. If we look at Slide 27, I want to talk to you a little bit or have us talk about how we actually cross-walk the codes from 9 to 10.

So everyone is having to do this.

All of your vendors, your software vendors, your clearinghouses, your payers, they're all in the process of cross-walking the codes from 9 to 10. There is not one crosswalk that is going to specifically map each ICD 9 code to a new ICD 10 code.

There are general equivalency mappings or GEMs and I had it explained to me that the GEM mapping may not get us to the house but it will get us to the right neighborhood and so you need to take that into consideration that the GEM mappings. You may need to check the code sets more specifically and make sure that you are using the correct code.

There are a lot of tools that use the GEM mapping and on the bottom of this Slide 27 there is a link to the CMS Website where the GEM files are located but the main thing I want you to understand is that there's not a one-to-one correlation so there's not going to be an easy cheat sheet for every code.

There's not going to be an easy go-to guide for all of your providers for every code. Now some of the mapping is more straightforward than other codes are but we don't have a one-to-one correlation. The next slide that we're going to look at is to show us a super bill example from ICD 9 to ICD 10.

We're on Slide 28. On our ICD 9 super bill, this super bill comes to us from the AAFP, gives us one code for acute bronchitis in 9 and if we were to look at our super bill - now this is not from the GEM files - this is just a super bill example, we have 10 codes of acute bronchitis in 10.

So we go from one possible code to 10 possible codes and this is just one example of just showing you how much more specific the diagnosis gets in 10 than in 9. We're going to talk about how do we assign a code and how do we know how specific we need to get in code assignment when we go into our next section of the call so this is just an example of a super bill.

Very few of us use a paper super bill anymore. Most of us are using a e-super bill or template or EHR to take that billing sheet from the EHR back into our practice management system but if we were using a paper sheet for bill, this is something that we might see.

So let's move on ahead and talk about how to use the code sets.

I find in most of my presentations the problems that we're having with using ICD 10 is that perhaps we're not using ICD 9 correctly. We're not assigning the codes correctly in 9 so any mistakes that we're making in 9, you know, there's a good

chance we're going to carry that over to 10 so we're going to talk a little bit about understanding the code sets.

On this Slide 30 I've given you several links. The ICD 10 CM index and tabular volumes are available to be downloaded from the CDC site. Now these are the same code sets that you're going to get if you purchased code manuals from a commercial publisher. They're not going to be as user-friendly in their format but it's going to be the same information.

And with each code set not only do we get the code set but we also get official guidelines on how to use those code sets and so your second link there is a link to the official guidelines for ICD 10 CM and again I've given you the link for the GEM mapping files again so I think that those are good resources for you.

If we turn the page now, I want to talk a little bit about some of the notes that are in ICD 10. These notes are not going to always be available when you look at the new code sets in your EHR so I think it is important that you have the code set either in a purchased manual or from the downloaded files because there's some valuable information in these notes.

So in ICD 10 one thing that's a big plus over 9 is that our code descriptions are completely written-out in a printed version of the code. We don't have the indented lines and the, you know, we don't have to get lost and go back up to find out what our parent line is in the code like we do in 9 now.

We have notes in 10 just like we have notes in 9 and we have excludes notes and these notes are going to be in the front of each code block when you look-up a code in the written version so we have two kinds of notes.

We have include notes and exclude notes so these are going to be our cue when we are considering assigning a diagnosis, what is included in this diagnosis, what is excluded and what else is needed. So we have two kinds of exclude notes. Exclude 1 means that 2 codes would never be used together under any circumstance, it's a pure exclusion.

And our Exclude 2 note indicates that although a specific condition may be reported - using this code, the 2 conditions can coexist together at the same time. So these are some of our notes.

On our next page, we're also going to have at the front of each code block notes which give us informational guidance on how to sequence the codes, when we need to assign an extra code and which code need to be assigned first.

Also we have NOS and NEC codes in 10 just like we have in 9. These codes are often - these types of codes - are often confused so when we have an NOS code it means that the clinical documentation doesn't give us anything more specific to make a more specific code assignment.

And an NEC note is where the clinical documentation may be pretty detailed but we can't exactly match it up with an existing code in the code set. So those are the difference between NOS and NEC.

I really want to urge you about the importance of the notes both the sequencing notes, the code also, the code first, the excludes and includes notes. These are going to be very, very important and I'm going to talk about it a little bit more when we get into end-to-end testing and some examples of where these notes have really proven to be very important.

So if we move on to the next page, this is just a sample of what the alphabetic index would look like if you were to download it from the CDC site. Again it's not as user-friendly as maybe the commercially-published book but it is available and then the next slide - Slide 34 - is going to show you the tabular (excerpt) so just wanted to let you know what those resources look like.

If we move on to 35 and I want to go over this briefly but we really can't camp-out on it too much, if we're using our EHR we're going to be using however that table is, how that displays to us in your specific EHR.

If we were to assign a code just using a book - a manual listing of the codes - we would start with the index and we would look-up the main term in the same way that we might search for a main term in your EHR but we don't stop there because we need to drill down for more information like we just did to look at the notes that pertain to a certain diagnosis.

So we're going to start with the index and then we're going to go to our tabular volume so I guess all of this to say is even if you're using an EHR and even if your EHR has really good tools embedded in it, you will need a code manual at your rural health clinic or at your practice or at your critical access hospital.

Someone is still going to have to be able to verify codes at some time so we're going to look-up that condition in the tabular. That's where we're going to find these notes that we've been talking about. That's where we're going to find out how many characters are needed to give us a valid code within that section of the code set.

The (rule) says that we are going to select, the most detailed code which supports the clinical documentation, we always code to the highest specificity and the highest number of characters that are required.

So if our patient has Otitis media right ear and our clinical documentation is going to say right ear, then the appropriate code to select is the code which states the laterality of the location of the infection so we always code to the highest specificity of the documentation. We always code to the highest number of characters required to give us a valid code.

So if we'll move on to the next slide, this is just kind of a flow chart which basically does a better job in telling you how to go through the assigning the codes. I kind of rambled a little bit a minute ago, sorry about that. Also if we go to Page 37 to Slide 37, we have guidelines for assigning diagnosis in an outpatient environment which includes our rural health clinics.

And I've bulleted a few of the things that are important when it comes to sequencing our codes. We have different rules, different coding guidelines for outpatient services than inpatient services. There are things that we're allowed to code for inpatient services that we are not allowed to code for outpatient services.

So you may want to review these rules with your providers and make sure that they understand the basics for assigning and sequencing the codes in an outpatient situation. Our first listed diagnosis is almost always the condition which occasioned the visit or the chief complaint.

We can also include other diagnoses that are coexisting or comorbidities which are present at the time of the visit and either affect our care or treatment like we know that comorbidities will affect how we treat certain illnesses or disorders.

Acute conditions are always listed above chronic stable conditions in sequencing and typically we do not report signs and symptoms which are integral to the definitive diagnosis and so you'll see an example there.

Please go over these and if your providers have any questions, include that in your education. We're going to move on along because I know this is where the rubber meets the road for most of us. We're going to move on to tips for ICD 10 implementation.

All of us have felt like that we've had stopped and started and stopped and started and it's kind of been a dry run and now October 1, 2015 is just a couple of months

away so I want to walk through with you how I guide clients when we're talking about ICD 10 implementation.

If you'll turn to Slide 39, the most important thing that you can do is make sure that you have had or will have good communication with every third party. This may be your practice management EHR vendor, it may be your clearinghouse, if you outsource your billing it may be your billing company and last but not least very good communication with your payers.

So when we talk about our practice management and EHR vendors and certainly you've had some communication with them and if you have any questions at all, this is the time to reach out to those folks, make sure that your system capabilities are on point, that you've had any updates or upgrades that all of your interfaces will work within your EHR.

Because we're looking at a different code format in ICD 10 and because we have so many more codes in 10, some of our user interface formats may change. Some of our templates may need to be redesigned.

The way that we access and view tables within our EHR may be different and these are things that you don't need to wait until October 1 to figure-out that your system is going to look different or you're going to navigate through your system differently than you have in the past.

This is the time to find out if you need updates or upgrades and who is responsible for those within your contracts with your vendors. When we talk about clearinghouses and billing companies, because our diagnoses are so much more specific we are going to see some billing edits and some claim scrubbing that we haven't seen with ICD 9.

One example that I have of that is some end-to-end testing was going on with a payer here in the south and a claim came through with a miscarriage, a missed abortion which is from our O chapter, Chapter 15 in ICD 10.

Our missed abortion code has a note that we only use this code if we are reporting a miscarriage before 20 weeks of gestation. We also have a note in that Chapter O which gives us instructional guidance to also use the 3A code which note the weeks of gestation.

In one of the test claims that went through, the diagnosis selected had been the missed abortion code but the additional Z code that had been submitted with the

weeks of gestation had 21 weeks listed so triggered a billing edit or possible denial because the two codes were invalid being used together.

So we're going to see billing edits and claim scrubbing that are a little bit different because of the increased specificity in ICD 10 and the additional reporting requirements in ICD 10. Please be in communication with your payers. Any bulletins they put out, any new claims instructions, any changes in their authorization processes or in their local coverage determinations.

These are going to affect how you report the codes and when you report the codes and you're going to really need to pay attention. Some of the codes like the external cost codes just like our E codes in 9 are at the discretion of the payer.

Our external cause codes in 10 are also going to be at the discretion of our payer as to whether they're going to require those or not so when you're coding guidelines say use an additional code, you need to make sure with specific payers whether they are or aren't going to be required to have a complete claim. Let's move on to Slide 40.

We all hope that we're not going to have any delays in claims that are cash flow. It's not going to be negatively affected by the ICD 10 implementation. We all hope that but in a managerial sense, we all need to be prepared for possibly our AR days to go up and this is where you need to be having discussions to make sure that you have cash reserves or credit lines setup in case you were to experience delays in claims processing.

We are going to have to dual-code so we need to think about capacity within our staff and within our systems to do we have the manpower and the resources to dual-code?

Just like our EHR impacted our productivity, just using the new codes and getting used to the new code structures and the organization of the code set has the potential of negatively impacting our productivity and the final bullet point on Slide 40 I always tell my clinics talk to your patients about what is going on.

Tell them that you're experiencing some changes and so they're not blindsided by your provider having to spend more time in the EHR or their insurance company not requiring a different authorization process now that we have new codes.

Just go ahead and give them a heads-up that you have something going on in your clinic and that it's not going to affect the care that they receive but it may affect, you know, some aspects of their encounter.

Now we just have a few minutes left before we want to go into the question and answers to if we go into what I consider the third and this is probably the most important aspect of implementing ICD 10 codes and I'm on Slide 41, you need to know what diagnoses you most commonly treat within your rural health clinic or critical access hospital now.

And you probably know those off the top of your heads. It's probably heart disease and diabetes and upper respiratory infections and, you know, what type of injuries your patient panel might typically present with.

But we need to identify those (top 50) codes, run a report out of your practice management system, also identify any specialty codes if you have visiting specialists that provide services within your RHC and then go through an exercise of mapping those codes from 9 to 10.

And when you're looking at that mapping, identify the specificity that may be required in the ICD 10 codes that are not required in the ICD 9 codes. What we also want to do is we want to analyze your current workflow processes, how is the code assigned in your practice? Are you fully using your systems? Is it an automated process? Is it a hybrid process?

Is it still a paper process? and identify where you might have gaps in assigning the codes and where your workflow processes might need to be changed to implement ICD 10 and again this is going to vary on how automated your processes now are and how well you're using your practice management and EHR system now so I always tell everyone look within your practice.

How do we assign a code now and what do we need to change to make that process transition to 10 and it may be requiring that you change some internal forms, some templates, some work processes. In a process of looking at these top diagnosis codes, you are also going to be giving yourself a heads-up on your educational needs.

And if we go on to Slide 42 I think most of these are kind of common sense. You don't want to over train your staff. You want to train your staff based on the role and the responsibility that they play in your clinic and you need to see educational resources that target specific needs.

We don't want to train our providers on OB coding if you don't see OB patients in your rural health clinics but if you do see OB patients and you do provide

women's health services then yes, you would want to train on that so we don't want to send our staff to a seminar or invest in resources that over train us.

We need to train methodically, use common sense and use our past encounters and history in case scenarios. Take something that you do every day in 9 and use that as an example for how you're going to transition to 10. I think they are just basically common sense kind of tips.

There are a lot of training materials out there. Your inbox is probably filled every morning just like mine is with somebody trying to sell you something, a book, a video series or get you to sign up for a Webinar. A lot of these resources are free.

They are provided from vendors just like I guess I'm a vendor of sorts. Select your materials carefully and just make sure that they apply to you and there again target your education to the needs of your staff based on the roles that they play.

If we go on to Slide 43, it's really important to know before we start in ICD 10 what our claims look like in 9, what kind of internal benchmarks do we have? What percent of contractual adjustments do we typically see now in ICD 9 so if we have a problem when we go to 10 we'll know my goodness, our contractual adjustments jumped-up 20%.

What's going on? so know what your normal claims process looks like now, know what your AR days are, know what your weaknesses in ICD 9 claims are now. Use some of the reporting capabilities within your practice management system. I'm always surprised that people don't know what reports are available and these are a great management tool for you.

But know what your claims processes look like in 9 so that you'll have a heads-up if you encounter a problem after we go to 10. There again here's our really simple little timeline. We are using ICD 9 codes prior to October 1, 2015. We are using ICD 10 codes for dates of service or discharge after October 1, 2015. Not too many months down the road for all of us.

The last slide here I've given you other possible resources that you would use. CMS has many, many, many tools, references, guidelines, tools based on the size of your practice. The American Medical Association, American Academy of Family Physicians, those have great resources if you do provide women's health, ACOG has excellent ICD 10 resources available to their members.

Resources are also available from AHIMA and AAPC, the coding folks and so here's just some resources that you could use as you further work on implementing ICD 10 and I guess that's it. I guess we can take questions and comments now.

Bill Finerfrock: All right, great. Thank you Patty, appreciate it. I think that was I found it very helpful, hopefully our audience did as well and they give some great tips and suggestions there. Hopefully people will take them to heart and begin doing some of the things if they haven't done them already. Operator, if you would give the instructions for taking the questions so that people can get into the queue that want to ask questions? Go ahead.

Coordinator: Thank you. At this time if you would like to ask a question, please press the star 1 on your touch-tone phone. Please be sure to unmute your phone and record your name clearly when prompted as this is needed to ask your question. To withdraw your question at any time, please press star 2. One moment for our first question.

Bill Finerfrock: And while we're waiting, I just want to reiterate a couple of things. I think on the date of service that's really important because in Medicare for example you can submit a claim up to a year after the service is delivered and it still meets the timely filing requirements.

So you literally could be submitting a claim in September of 2016 for a service that was provided in September of 2015 and you would be using an ICD 9 code to do that because it was a date of service of 2015 prior to the effective date so the date of service is really critically important to keep in mind here.

Also to take advantage of testing opportunities with the payers, with your clearinghouses, whomever you partner with because of the kinds of examples and the reasons Patty identified where they may be claim interactions or code interactions that cause a claim to be rejected under ICD 9 that would have passed muster, past edits easily under ICD 9.

So please take every opportunity to take advantage of those testing opportunities. Operator, do we have any questions?

Coordinator: We do have one question from (Dan). Your line is now open.

Bill Finerfrock: (Dan), if you could identify where you're calling from, your name and what city and state?

(Dan): Yes, I'm (Dan) from (Canby), Cal, (Canby) family practice clinic, we're a rural health clinic here in Northern California.

Bill Finerfrock: Great, what's your question?

(Dan): My question is can we identify some of the payers or some of the entities which will not accept the ICD 10 codes even after they go live?

Bill Finerfrock: Well, all HIPAA-regulated plans are required to accept ICD 10 after the October 1 of 2015 date. The only ones that I know of and Patty you can correct me are workmen's comp and automobile insurance that would be processing a health claim are not required to go to ICD 10 but all health plans covered under HIPAA are required to go to ICD 10 as of October 1, 2015. Are there any others, Patty?

Patty Harper: Yes, that's all that I'm aware of, Bill, and I've heard that some of the worker's comp and this of course is state to state, if they are planning to go to ICD 10 as well so yes, all HIPAA-covered entities will be using ICD 10 codes as of October 1, 2015.

(Dan): Very good, thank you.

Bill Finerfrock: Okay. Operator, do we have any other - hello?

Coordinator: Again if you would like to ask a question, please press star 1.

Bill Finerfrock: One of the again while we're waiting Patty, in terms of documentation, I think that's really important. A lot of times folks think of this as strictly a coding update but really it does require additional information be in the documentation in order to be able to code to the level of specificity.

You pointed-out for example laterality so in the documentation, you know, it needs to note left, right, midline, those things. Can you expand on that a little bit?

Patty Harper: Certainly. I think that more commonly we see that the documentation is detailed but in ICD 9 we've opted to assign a non-specific or a general code and there again I would just remind everybody that we are supposed to assign the diagnosis code based on the level of specificity within the documentation.

So I find that we're not assigning the codes correctly in 9 because maybe we have more information in the clinical documentation but we're opting to use a general code like our codes that end in 9 in ICD 9 so that will be part of looking at your top 50 diagnosis codes and going back and looking at your documentation and kind of doing a self-audit to see if your documentation, what is the quality of our documentation?

Are there areas where we need to beef-up our documentation and this may be where you want to revise some of your EHR templates. It may be where you want to focus on provider education to make sure that you're capturing the specificity that the new codes want us to use to report. I don't know, does that make sense?

Bill Finerfrock: Yes. Operator, do we have any questions from the audience?

Coordinator: And there are no more questions in queue at this time.

Bill Finerfrock: We're got another minute or two here. One of the things if we could kind of stay on this specificity and documentation and I think you touched on it a little bit but one of the things I've encouraged folks is to take their current documentation and try and code at a just as a task within your practice, code it to an ICD 10 level to try and identify whether there are deficiencies in your documentation.

Is that something you encourage folks to take a look at, that's something simple that they can do now without the need for anybody from the outside?

Patty Harper: Certainly, certainly, and I would deal with, you know, what they treat most commonly is an easy way to do that. Our RHCs already should have some utilization review process, you know, in where they're looking at the quality of documentation.

And they should be having chart reviews so yes, incorporate looking at that documentation through the lens of ICD 10 would be a perfect easy way to identify opportunities to improve the quality of clinical documentation.

Bill Finerfrock: Okay, operator, if we don't have any other questions, then we'll go ahead and close this out and make some closing remarks and then we'll finish-up today's call. I do before making our general comments, this is going to happen, folks.

We see as I said no indication that there are going to be any further delays either by Congress or by the administration and so you really should take this seriously. The consequences of not doing this and not taking it seriously as Patty mentioned in one of her slides is that you could experience disruptions in cash flow and problems and we don't want to see that happen.

We recognize that this represents some challenges, could have an adverse impact on cash flow in the near term, could affect practice productivity and all of those things may not be good in the near term for you and your patients. We can't stop it. It's going to happen and the sooner that folks simply accept that and begin

doing the things that we need to do to be prepared to submit claims using an ICD 10 platform, I think the better off everyone will be.

So the recording of today's call will be available for download in a few weeks. The slides for today's call were made available. If you don't have them, send me an e-mail at [info@narhc](mailto:info@narhc) and I'll be happy to send them to you. They're also available on the NARHC Website.

I'd like to thank everyone on today's call and especially Patty Harper, our speaker for her presentation along with our partners the National Organization of State Offices of Rural Health, the Federal Office of Rural Health Policy for the Rural Health Clinic technical assistance series.

Please encourage others who may be interested to register for the RHS series. In addition we welcome you to e-mail us with your thoughts and suggestions, for future call topics and you can send those to [info@narhc.org](mailto:info@narhc.org) and please put RHCATA topic in the subject line.

We anticipate scheduling our next RHCATA call for mid-July and a notice will be sent by e-mail to those who've registered for the call series with the details on that call. Thanks again for your participation and have a great rest of the week and rest of the day. Thank you.

Coordinator: This does conclude today's call. All participants may disconnect at this time.

END