



ICD-10 and HIPAA 5010

Impacts and Preparedness of Payers

Executive Summary

The US Healthcare system has endeavored to give providers a systematic way to classify diseases in order to standardize the way the providers' bill for services and ensure accuracy of payments by insurance companies. Most of the world's developed healthcare systems follow the World Health Organization (WHO) International Classification of Diseases (ICD). This coding scheme is used to classify morbidity and mortality data for vital statistics tracking and for health insurance claim reimbursement.

Since its inception, the ICD has undergone a number of iterations. The US Government mandated the move from the ICD-9 system to an expanded ICD-10 version to be implemented by October 1, 2013. This is a far more complex scheme reflecting changes in disease detection and treatment regimens.

In addition, the government has also mandated an upgrade of the nine HIPAA transaction formats for electronic data transmission from the initial 4010 version to version 5010. The deadline for this implementation is January 1, 2012 to accommodate the expanded ICD-10 codes.

These changes require a massive overhaul of the nation's medical coding system because ICD-9

codes are deeply embedded as part of the coding, reporting, and reimbursement methodology in use today.

In order to develop an effective consecutive implementation for these two major changes will require strategic planning to include training, interaction with vendor systems, changes to internal legacy systems, benefit and provider contractual changes, and testing to ensure a transparent changeover.

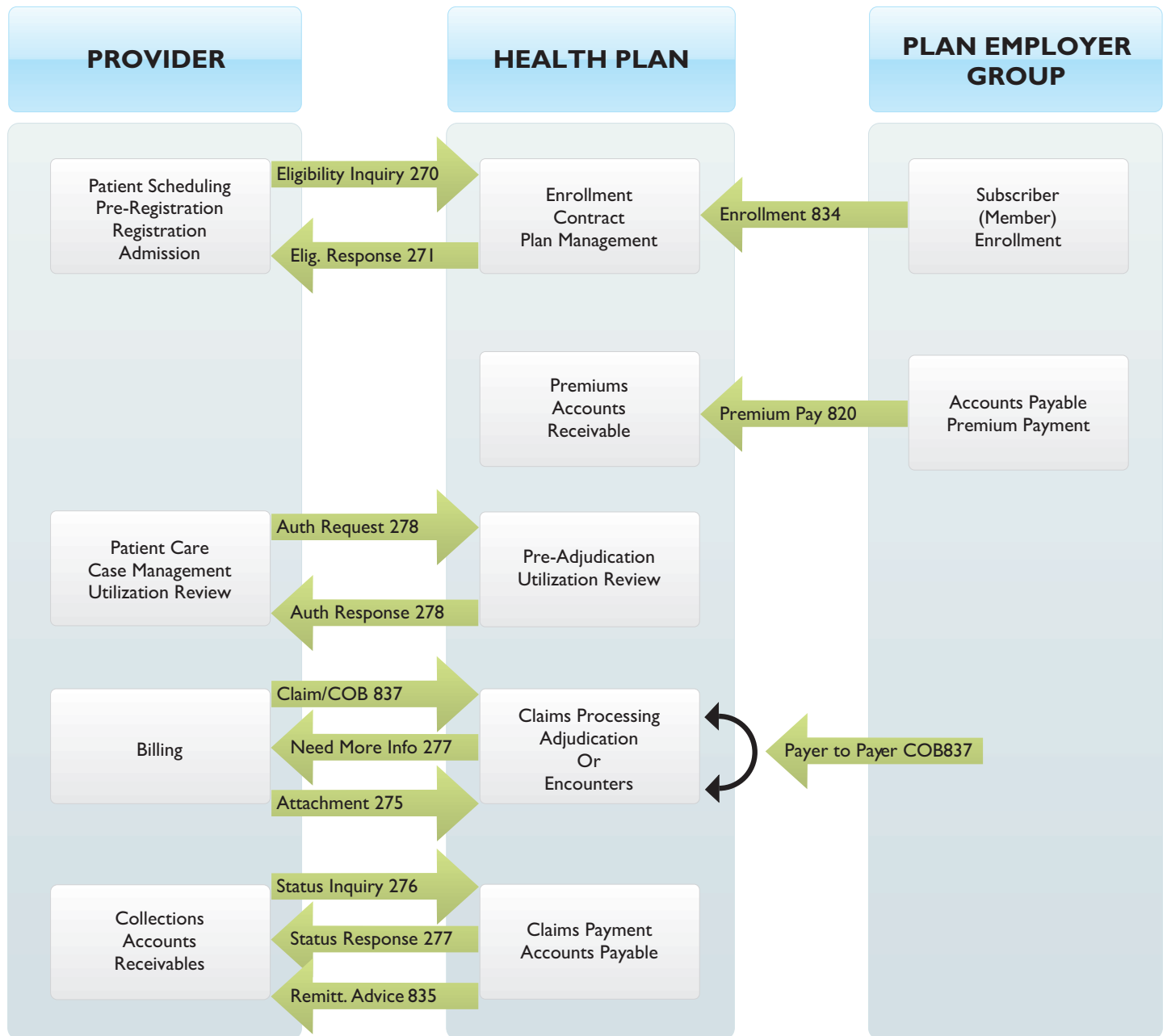
All of this must be completed while maintaining business as usual. Further, these are unfunded mandates that require healthcare stakeholders to provide significant resources and funding themselves.

This paper provides an understanding of the HIPAA and ICD code sets as well as the benefits to be derived and the critical success factors that must be met in order to successfully complete these complex transitions.

HIPAA X12 4010 to 5010

What is the 4010 to 5010 conversion and what does it involve?

Version 4010 was adopted on August 17, 2000 and included standardization of 9 formats for electronic data transmissions (paper transactions are excluded at present). They included:



The 5010 Version is massive and includes more than 850 complex changes. For example, the changes to the Healthcare claim, transaction 837, include 700 pages of instructions with a change on every page. This HIPAA format conversion must be completed by January 1, 2012, in advance of the ICD-10 implementation in order to accommodate the extended diagnosis/procedure codes.

It is also critical that during the 5010 conversion, payers and providers operate dual processing systems - one to process live claims with 4010 formats and a second to process 5010 transactions for testing and analytics.

Approach to HIPAA 5010 compliance

- Change analysis will require a thorough review of all transactions
- Each payer should review their 4010 AI implementation against 5010 guidelines, with particular attention to situational rules
- Changes are not 100% with some transactions changing very little, some moderately, and others, such as claims transactions, changing dramatically
- New interfaces must be identified and built
- Data elements must be assembled to match the 5010 layout and tested thoroughly
- Implemented in compliance with the mandated completion date of January 1, 2012

ICD-9-CM TO ICD-10-CM AND ICD-10-PCS

How are ICD-10-CM and ICD-10-PCS different from ICD-9-CM?

When the original ICD code sets were adopted by the World Health Organization, they did not include procedure codes for facility providers. The ICD-9 code sets included 13,000 diagnosis codes and no procedure codes. At that time, the US healthcare industry added 11,000 facility procedure codes and designated the combined codes set as ICD-9-CM.

The new code sets are now in two segments. ICD-10-CM increases diagnosis codes from 13,000 to 68,000 codes. The accompanying ICD-10-PCS code set includes facility procedure codes and increases the total content from 11,000 to 87,000 codes. The mandated implementation date for both code sets is October 1, 2013.

Together, these two expanded code sets will enable far more effective data for the vital classification of morbidity and mortality data while enabling accurate claims management and reimbursement by the insurance industry. They will advance effective disease management programs and track outcomes of care to ensure quality.

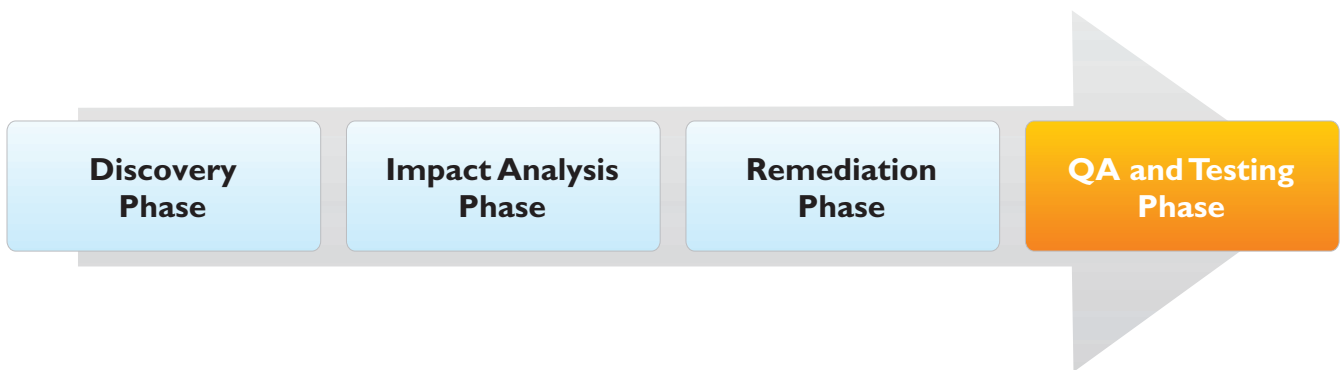
To effectively undertake the massive projects, these two interdependent conversions require, and to complete implementation within the time frames mandated by the Federal Government, there are key strategic steps we recommend be followed. To follow are 10 Critical Success Factors we have identified to ensure understanding of the changes themselves, the areas within the payer that will be affected and the steps to be completed to meet these very complex, resource dependent and unfunded mandates.

What are the critical success factors that will determine a successful implementation strategy?

Following extensive analysis, eMids has identified the following 10 critical areas that must be addressed to complete these complex conversions:

1. Implementation approach

A phased approach to accomplish successful implementation of these complex changes:



Discovery phase An up-front analysis to identify processes impacted and catalog issues related to benefit changes, provider contracts, state regulatory mandates, medical case management policy changes, staffing issues, testing, and vendor management.

Analysis phase Each affected system, process, or staff grouping would undergo an in-depth analysis to determine the extent of impact. The exit criterion is a detailed matrix identifying the magnitude of impact in each area.

Remediation phase The Discovery and Analysis phases will result in a detailed roadmap to enable compliance to 5010 and ICD-10 criteria. This includes re-engineered solutions, validation, implementation, and testing for go-live production.

2. Plan impact mitigation

There will be a threefold impact involving people, process, and technology. The impact on staff will involve various levels of training in the following areas:

- Coding non-EDI claims
- Suspend Claims Review
- Processing Referrals/Authorizations and Medical Case Management
- Provider Contract Development
- Customer/Provider Inquiry Resolution
- Internal Fraud and Abuse and SLA Audits
- Data Analysis
- Others to be determined during Discovery Phase

The complexity of these mandates impact virtually every system and process involved with claims, including but not limited to:

- Benefits
- Provider Payments
- Claims Adjudication and Payment
- Clinical Case Management
- Data Warehouse and Business Intelligence
- Vendor Software
- Others to be determined during Discovery Phase

Although vendor software should be updated through vendor releases, payers need to test the integration of those vendor systems with in-house systems.

In addition, a crosswalk between the ICD-9-CM version and the new ICD-10-CM and ICD-10-PCS versions to ensure compatibility between previously paid and current claims to ensure benefit and member liability calculations.

One of the most critical functions necessary will be complete testing of all internal and vendor software changes throughout the process.

Two types of testing activities are envisioned for ensuring seamless compliance:

- Testing on the payer's own side without synchronization of EDI messaging from outside vendors. During this time, the payers need not have to synchronize their testing activities with their third party vendors but with internal systems from the enrollment engines that accept the EDI 5010 messages to the claims engines that adjudicate based on the new ICD-10s
- Testing with all the players involved with synchronization of input and output messaging with providers. Both types of testing require in-depth knowledge of the processes

Because of the complexity and scope of the mandates, we suggest the entire testing apparatus and process be highly controlled as the effectiveness of this function will be key to avoiding negative impact to the payer's entire customer base.

3. Communications strategy

Communications with internal staff, product vendors, providers, and employers will require transparency, timeliness, and accuracy with each stakeholder group. This includes the following

- Internal staff communication and training. Specialized levels of training need to be developed for individuals from new claim coders through to medical case management professional staff
- Communications with product and application vendors to determine dates of releases and test dates; this must include go-live and regression testing dates of key milestones
- Communications with providers, employers, and members to ensure their understanding of the specific impact and timing of these upgrades. Every effort should be made to avoid a flood of inquiries and appeals due to benefit or reimbursement changes

4. Develop scope and approach for potential changes in contracts and benefits

Member benefits in place at the time of the 5010 and ICD-10 conversions should not be impacted as they are typically renewed annually. However, if the analysis phase determines benefits could be affected, it will be necessary to develop employer, member, and regulatory communications.

Provider payments could be impacted based on the reimbursement methodology of their contracts. The provider segment paid under DRG agreements may require modifications to adjudication rules and vendor software.

It is also possible that accreditations/specialty designations might require amendments. Any impact will be determined in the analysis phase.

5. Create a plan to engage vendors

Following early identification of interactive vendor systems, determinations must be made of the plan and effectiveness of each vendor's conversion strategies and how they impact the client. In most instances vendors should amend systems via releases thereby requiring internal integration and testing by the payer. Smaller, niche-type vendors may require greater interaction.

6. Manage complexities of testing

Several levels of testing are required for ICD-10 implementation; first would be vendor development and testing, then internal implementation and testing, and then testing with trading partners. These pieces will cause disruption in ongoing operations, and must be integrated into the day to day operations of the practice. This will ensure a smooth flow of testing simultaneous transaction and coding conversions.

7. Identify and address discontinuity between ICD9 and ICD10 on CM, DM and UM

It will not be practical to attempt to convert existing claims history records. It will be necessary for payers to develop a crosswalk between paid/denied claims in history and new claims after the ICD-10 conversion date. This crosswalk will be critical in medical case management and could be a factor in development of benefits and member out of pocket liability and will involve:

- All claims adjudication systems and processes
- Processes and applications to determine medical necessity and medical appropriateness
- Process and applications used for pre-authorization or pre-certification of services
- Disease management applications and processes
- Research and analysis activities use applications, processes, and data warehouses
- Provider quality oversight programs
- EDI Crosswalks

8. Develop plan to coordinate 5010 and ICD-10 implementation

HIPAA 5010 modification specifications include more than 850 total changes involving the 9 existing HIPAA electronic transactions. Some transactions will change very little, but the most significant changes involve the claims transactions. The HIPAA X12 Version 5010 standard is a prerequisite for implementing ICD-10. Data in the ICD-10 segment has been rearranged, titles changed, and some diagnosis conditions regrouped. The number of modifications to legacy systems will vary based on the number of applications and databases affected.

ICD-10 consists of two sections - ICD10-CM provides diagnosis codes and replaces ICD-9 Volumes 1 and 2, ICD-10-PCS provides procedure codes replacing ICD-9 Volume 3. The efforts between the two mandates (5010-Jan 2012 and ICD-10-Oct 2013) should be distinct in the sense that the conversion of 4010 to 5010 modifies the data fields in the HIPAA transactions.

The codes that will be used by providers to populate those fields will be accommodated through changes in their practice management systems. The ICD-10 changes will primarily impact the payers due to the large number of systems and processes and levels of training that will be required.

9. Update and publish supporting medical policies

The conversion of ICD-9-CM to ICD-10-CM will increase diagnosis codes used for inpatient and outpatient facilities from approximately 13,000 codes to 68,000 codes. ICD procedure codes for inpatient facilities will increase from 11,000 to 87,000 codes.

It follows, therefore, that individual payer medical policies, whether mandated or internally developed will require review and updating. Such policies involving lengths of stay, medical necessity criteria, etc. will require review by clinical staff and appropriate parameters adjusted. Criteria affected by these changes will require updating internal rules, communication with appropriate medical associations, peer review committees, and updating medical management software.

10. Identify and develop internal training material

Payers will have to develop or purchase vendor developed training materials. The train the trainer approach would be most productive and should be part of the earliest strategy. It is anticipated that training programs are already in the market or under development which may prove to be the most effective and economical method for staff training. However, such programs will need to be supplemented by internal system and procedure changes unique to local benefits and policies.

Appendix

Major differences

ICD-9-CM vs. ICD-10-CM

13,000 Diagnosis Codes	68,000 Diagnosis Codes
3- to 5-digit Codes	3- to 7-digit Codes
Code Format:	Code Format:
<ul style="list-style-type: none"> Numeric Codes for all Chapters Alphanumeric for Supplementary Chapters (V-codes and E-codes) 	<ul style="list-style-type: none"> Digit 1 is alphabetic Digits 2-7 are numeric
No Dummy Placeholder	Presence of Dummy Placeholder

ICD-9 Volume 3 vs. ICD-10-PCS

11,000 Procedure Codes	87,000 Procedure Codes
3- to 4-Digit Codes	7-Digit Codes
Code Format : Numeric	Code Format : Alphanumeric

The following example demonstrates the advantages of PRECISION and ACCURACY of ICD-10-CM over ICD-9-CM

ICD-9-CM	Description	ICD-10-CM	Description
493.92	Acute asthma exacerbation	J45.21	Asthma, mild, intermittent, with acute exacerbation
		J45.41	Asthma, moderate, persistent, with acute exacerbation
		J45.51	Asthma, severe, persistent, with acute exacerbation

The following example demonstrates the advantages of LATERALITY

Description	ICD-9-CM	ICD-10-CM
Ototoxic hearing loss, right ear	389.8	H91.01
Ototoxic hearing loss, left ear	389.8	H91.02
Ototoxic hearing loss, bilateral ears	389.8	H91.03
Ototoxic hearing loss, unspecified ear	389.8	H91.04

eMids Transition Services Offerings

Impact Assessment

Assessing and analyzing existing coding and reimbursement systems, data sources and decision-support systems

Evaluating Interfaces between code entry department and electronic billing using the UB-04/HCFA 1500 format

Reviewing financial information connected with reimbursement

Review clinical, PACS, EMR et.al. systems

Remediation

Solution design

Business rule configuration

Mapping

Integrations

Trading partner agreement configuration

Coding

Deployment & Go-Live

Support & Maintenance

QA & Testing

Test consulting

Functional testing

System testing

Regression testing

User acceptance testing

Performance testing

Volume testing

Stress testing

Test automation

eMids has a pre-designed solution developed at its transition services center of excellence for:

- Automated impact assessment
- Templated business analysis Code remediation technique
- Data migration technique
- Transition crosswalks Automated QA & test framework

The team at eMids has expertise in EDI transactions, claims processing and healthcare IT coupled with experience in medical sciences, for enabling successful transition.

For detailed discussions on eMids offerings and successful case stories on transition services, please contact:

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Abbreviations

ASC

Accredited Standards Committee

DRG

Diagnosis Related Group

EDI

Electronic Data Interchange

HIPAA

Health Insurance Portability and Accountability Act

ICD

International Classification of Diseases

ICD-9/10 CM

International Classification of Diseases-Clinical
Modifications

ICD-10 PCS

International Classification of Diseases-Procedural
Coding System

NPI

National Provider Identifier

Parting thoughts

“ICD-10 and 5010 implementation give strategic advantage in the long term”

“Payers are impacted heavily in all functions hence should proactively prepare themselves”

“eMids is ready with a transition solution and service for quick and seamless compliance”

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About eMids

eMids helps its customers remain at the forefront of their industries and operate their businesses more efficiently through innovative use of technology. eMids deliver flexible, custom IT and BPO solutions through vertical practices and a Global Delivery Model (GDM) that improves quality and optimizes costs.

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