

# **The Opportunities and Challenges of ICD-10**

**A FOX White Paper**



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On January 16, 2009, the United States Department of Health and Human Services (HHS) published a rule to adopt the *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) for coding diagnoses, and *Procedure Coding System* (ICD-10-PCS) for coding inpatient hospital procedures, which replace the *Ninth Revision* (ICD-9). The ICD-10-CM code set for diseases is maintained by the National Center for Health Statistics, a branch of the Centers for Disease Control and Prevention (CDC). The ICD-10-PCS code set is maintained by the Centers for Medicare and Medicaid Services (CMS).

- Information related to the final rule and the code sets can be found at: [http://www.cms.hhs.gov/TransactionCodeSetsStands/02\\_TransactionsandCodeSetsRegulations.asp](http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp)
- Additional information related to the ICD-10-CM can be found at the National Center for Health Statistics web site: <http://www.cdc.gov/nchs/about/otheract/icd9/abtcd10.htm>

The compliance date for implementation of ICD-10 is October 1, 2013. This is a single compliance date, and does not make allowances for smaller providers or smaller health plans. Health care provided with dates of service prior to October 1, 2013 must contain coding from the ICD-9 code set currently in use, while services after the compliance date must contain coding from ICD-10. Without question, this will be a significant undertaking for both providers and health plans.

### Why Do We Need ICD-10?

- The ICD-9 code set is over 30 years old and relates to diseases and treatments of that period. The World Health Organization (WHO) developed ICD-10, and it has been in use in most of the developed countries for many years. The United States is one of the remaining holdouts for transition to the ICD-10 code set, which means we cannot appropriately compare our health care to any other developed country.
- ICD-9 has a limited number of codes and certain sections of the code set are out of code space. This has meant that some new diseases have been placed in sections that have space, but have no other relationship, making it a difficult code set to use and update. For instance, new types of tumors or new types of communicable diseases might suddenly be found in a section relating to eyes.
- ICD-9 codes are more generalized and rely on phrasing such as “not elsewhere classified.”
- ICD-10 codes allow for more detail and include reference to laterality (right versus left) to define organs or body parts that come in pairs.
- There is plenty of space available in the ICD-10 code set to allow for emerging diseases and procedures.
- ICD-10 represents new technology and medical advances and enables a linking of diagnoses to the use of these new procedures, tests, and medications to demonstrate their effectiveness or necessity.
- The diagnosis code set enables differentiation of individual fetuses in multiple pregnancies.
- Preventive health, external causes of injury, and behavioral health issues are all substantially better represented in the ICD-10 code set.

## What is the Difference between ICD-9 and ICD-10?

- ICD-9 volumes 1 and 2 (diagnoses) have approximately 13,000 codes, while ICD-10-CM has about 68,000 codes.
- ICD-10 codes have infinitely more detail, which means they don't map well backward to the more generic ICD-9 codes. In one instance, one ICD-9 code (an unjoined fracture) is represented in ICD-10-CM by over 2,500 detailed codes that name the fracture and the bones involved. There are huge care implications between a fracture of the little finger of the left hand that is unjoined and one of the thigh bone. The thigh fracture will have implications for ambulation, transportation, self-care, nutrition, and potential complications due to immobility.
- ICD-9 codes have a minimum of 3 digits and a maximum of 5, with only the letters E and V used, while ICD-10-CM has a minimum of 3 alphanumeric characters and a maximum of 7.
- ICD-9 volume 3 (procedures) has approximately 4000 codes, while ICD-10-PCS has about 72,500 procedure codes.
- ICD-9 procedure codes use 3 to 4 numeric digits with a decimal after the second digit, while ICD-10-PCS uses 7 alphanumeric characters to represent the procedure and each digit represents specific logic associated with the procedure.

## What are the Benefits of ICD-10 for Medicaid Enterprises?

- Payment will be more accurate due to the detail evident in the diagnoses and procedures. Diagnosis-related Groups (DRGs) will reference numerous diagnosis codes to determine complications and co-morbidities (C&C) or risk adjustments for the complexity of multiple diagnoses.
- There may be less necessity for prior authorizations or for requesting additional information from providers because the detail may be sufficient to assure payment.
- There should be fewer rejected claims or improperly submitted claims.
- Claim editing will enable matching of diagnoses to procedures, matching of diagnoses to the type of provider that should treat this client, better matching for duplicate claims, better matching of diagnoses to pharmacy claims, and better matching of diagnoses to prior authorization requests.
- ICD-10-CM enables more selective sorting of disease processes to enable care management processes to be put in place before complications occur.
- Diseases can be compared across populations and public health structures to determine if evidence based practices produce the desired effect. Standards of care can be developed, monitored, and funded in a pay for performance (P4P) structure.
- Interventions can be measured against diagnoses to assure maximum effectiveness for the most cost-effective price. For example, a state can measure whether or not members receiving the most expensive drug interventions actually have better results, or whether providers are quick to jump to the latest treatment options.
- Program Integrity (PI) and Quality Assurance (QA) activities should be more specific and more detailed:
  - Members can be sorted by distinct diagnoses for specific review.
  - Providers can be sorted by their treatment of specific diagnoses for review.
  - Members can be distinguished by their diagnoses to locate appropriate treatment protocols versus some forms of abuse.

- Trending can be done to match the uses of interventions over time by provider or member by diagnosis.
- Care can be compared between members in fee-for-service (FFS) programs versus managed care and can be monitored for cost and standard of care.
- Drug utilization review (DUR) and other QA processes can be much more specific.
- ICD-10 will be a critical piece to movement along the Medicaid Information Technology Architecture (MITA) maturity model levels.

### **What Will Be the Impacts of ICD-10 on the Medicaid Enterprise?**

- Medical policy will change by the decisions made to pay for care defined by the ICD-10 diagnoses or the ICD-10-PCS procedures.
- Benefit plans will be designed around various diagnoses or multiple diagnoses.
- Vendor/contractor management will require consideration:
  - Prior authorization vendors must receive and process ICD-10.
  - Fiscal agent contracts will evolve around the ICD-10 transition.
  - Quality management contracts will change to consider the new detail available in ICD-10.
  - Pharmacy benefit management will change as more diagnoses are supplied with prescriptions.
- Data reporting will change as required by CMS, Health Resources and Services Administration (HRSA), CDC, or other federal funding sources as well as state funding.
- Disease and care management will change as diseases can be more specifically isolated and care managed on a less global basis.
- Trend analyses will require conversion of ICD-10 to ICD-9 for a period of time to compare pre- and post-ICD-10 data.
- Quality assurance and program integrity activities will be impacted by the ICD-10 transition.
- States must determine how they will handle non-covered entities and atypical providers when diagnosis information is used.
- Staffing considerations may be necessary to assure that clinical and coding expertise is available for the transition.
- Crosswalks in and out will have significant issues and should be a major factor to consider.

### **What Are the Impacts to MMIS Systems?**

- Field size for diagnoses will change from 3-5 characters to 3-7 alphanumeric characters.
- Field size for hospital procedures will change from 3-5 characters with a decimal to 7 alphanumeric characters with intelligence in each character.
- Systems must accept and process all of the available diagnoses and procedure codes that can be submitted on claims. Systems that can only process 1-4 diagnoses will limit the state's ability to manage disease complications and care, and monitor provider performance and costs.
- Logic will need to be modified to consider more specific payment methodologies and variabilites.

- Algorithms may require changing to accommodate the ability to match diagnoses to other coding structures, such as procedures, provider identifiers, member identifiers, etc.
- Historical trending may be complicated. Most history will not be converted, so it must be compared by crosswalk. Data warehouse and decision support systems must support the comparisons.
- Two versions, ICD-9 and ICD-10, must be supported during the transition, depending on the date of service and the provider submitting the claim (atypical or covered entity).
- Some backward crosswalks (ICD-10 to ICD-9) will have multiple ICD-10 codes to a single ICD-9 code and situations where one ICD-10 code maps to more than one ICD-9 code. Medicaid must decide what to do with how very specialized codes match very generic codes within their systems or make system changes to add all of the ICD-10 codes with independent logic.
- Some ICD-10 codes will have no comparison because they are new. Over time, these must be added with logic, algorithms, and code structure to the various Medicaid Management Information Systems (MMIS).
- Where diagnosis codes touch other systems, or where other systems may process specific types of claims, the change to ICD-10 must be carried forward, e.g., Prior Authorization (PA) systems that may be managed by vendors, separate behavioral health or waiver systems, or Drug Utilization Review (DUR) processes conducted by vendors.
- The Pharmacy Benefit Manager (PBM) will need to accept diagnosis codes in the ICD-10 format received on prescriptions.
- Shared systems or ad hoc systems will need to exchange ICD-10 back and forth.
- ICD-9 codes that do not match any ICD-10 codes will need to be timed out of the system.
- ICD-10 codes must be returned on eligibility inquiries if the provider supplies the code on the inquiry and if the health plan uses ICD-10 codes to determine eligibility. This may significantly change eligibility systems.

### **How Does ICD-10 Impact MITA and the Medicaid Business Processes?**

- All of the MITA business areas and most of the MITA business processes will be impacted in some manner by ICD-10. Some of these impacts present great opportunities.
- Claims processing and proprietary remittance advices may need to be able to carry ICD-10.
- The data warehouse must carry the ICD-10 and enable the crosswalk for comparisons.
- Program policy will need to consider payment structures and edits and audits.
- Prior authorization processes will need to consider diagnoses and may not be necessary, depending on the specificity of the diagnosis and procedural coding.
- Program integrity and research processes will change based on the crosswalk and recognition of new codes.
- Member files may need to carry diagnoses related to care management, benefit plans, and member disease profiles. For example, a member may be initially assigned to a care management program related to diabetes in pregnancy, but then may be changed to a regular diabetes care management program after delivery.
- Provider files may be changed to only allow specific providers to manage specific diagnoses. Neurologists, for example, perhaps should not be managing obstetrical care. These provider file details may also be used for P4P, or to conduct provider report card processes.

- Management of programs and reporting must enable comparison of historical files to new coding structures through crosswalks.
- Quality assurance, risk management, patient safety issues, etc., will be easier to manage with more specific coding, but the concepts regarding how to use diagnosis information will necessarily change. Program managers must be aware of these impacts and be prepared to accept the opportunities presented in this significant transition.
- Care planning actions, such as those for long-term care, disabilities, special populations (cancer, transplants, children, AIDS, pregnancy) will change with new diagnosis and inpatient procedure information.
- Risk adjustments for severity of illness (DRGs, APGs, etc.) will change with new diagnosis information.
- Encounter data, to be comparable with FFS data, must carry the same information and must carry the same number of diagnoses and procedure codes. Decision Support Systems (DSS) must be able to compare the information according to the provider or payer source.
- Participation in Electronic Health Records (EHRs) at MITA maturity model level 4 will require the ability to exchange ICD-10 diagnosis and procedure codes and use that data appropriately.
- Coordination of benefits with other payers, such as Medicare, other health plans, workers compensation, automobile/life insurance, etc., will be impacted by the exchange of ICD-10 diagnosis and procedure codes.
- Grievance and appeal processes may change as providers may expect to be paid more for more extensive procedures and care for sicker patients.
- Dual eligibles, for Medicare and Medicaid, must coordinate the meaning of various diagnoses and procedures, since some may be depending on crosswalks, while others have incorporated the exact codes.
- Expect a rise in the Payment Error Rate Measurement (PERM) during the transition.
- MMIS certification will be dependent upon the ability to use ICD-10 in upgraded systems and report to CMS appropriately.
- Contracting processes will change due to the state's expectations of contractors to receive and process ICD-10-CM and ICD-10-PCS.
- Fee schedules and any other rate structures must be reviewed and changed.
- Manuals to providers, policies and procedures to internal staff, and communications to other partners must be revised.
- New codes must be researched and added on an ongoing basis. This may require coding expertise within the state or fiscal agent or both.

### **How Should Medicaid Enterprises Plan for the ICD-10 Transition?**

- Plan well and plan early. Activity should already be underway in order to make the transition in time. The American Health Information Management Association (AHIMA) recommends four years to prepare and transition to ICD-10.
  - Decide on your strategy—crosswalk only, internal use of exact codes, or some combination.
  - Begin a detailed implementation project plan and follow it using project management principles.
  - Assess systems and locations of diagnosis and hospital procedure coding.

- Assess current uses of diagnosis and hospital procedure coding.
- Assess potential and opportunity uses of diagnosis and hospital procedure coding.
- Make your policy change plans and begin to condition staff to the upcoming changes.
- Train staff by general orientation and then more progressive and detailed training as the project progresses.
- Establish workgroups to define the coding issues and make determinations regarding coverage, rules, edits, etc.
- Plan your systems changes and design, development, and implementation (DDI) very carefully and include this in any vendor contracts and future Request for Proposals (RFPs).
- Track your conversion process, and don't get off course.
- Test internally and then externally.
- Train staff, providers, and contractors to the decisions and plans you have made.
- Watch your progress and costs carefully.

### Where Can I Get More Information?

- ICD-10-PCS, Power Point, training packages and rules are available from CMS at [www.com.hhs.gov](http://www.com.hhs.gov)
- ICD-10 crosswalks and guide to crosswalks from CMS [http://www.cms.hhs.gov/ICD10/downloads/reimb\\_map\\_guide\\_2009.pdf](http://www.cms.hhs.gov/ICD10/downloads/reimb_map_guide_2009.pdf)
- American Health Information Management Association (AHIMA) [www.ahima.org](http://www.ahima.org)
- General Equivalency Mappings (GEMS) on NCHS website [www.cdc.gov/nchs/icd9.htm](http://www.cdc.gov/nchs/icd9.htm)
- Workgroup for Electronic Data Interchange (WEDI) ICD-10 workgroups [www.WEDI.org](http://www.WEDI.org)

### About Fox Systems, Inc.

Fox Systems, Inc. (FOX) is a nationally recognized consulting practice that provides information systems and operations consulting services to public and private sector healthcare clients. FOX specializes in consulting services related to large-scale information systems that support state Medicaid programs, Managed Care Organizations, Pharmacy Benefit Managers, and Clearinghouses. Incorporated in California in 1987 by Susan J. Fox, PhD., FOX is a privately-held company, with woman-owned certification in several states. We maintain corporate headquarters in Scottsdale, Arizona, as well as numerous field offices throughout the country to facilitate the completion of major contracts.

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