



**State of California  
ICDD-10 Site Visit**

Training segments to assist the State of California with the ICD- 10 Implementation

**Segment 5: Claims Management**

June 10-11, 2013



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graph TD
    A[MITA and ICD-10 Support National Quality Strategy] --> B[ICD-10 Overview]
    B --> C[Analytics and Reporting]
    C --> D[Program Integrity]
    D --> E[Policy Remediation Best Practices]
    E --> F[Managed Care]
    F --> G[Claims Management]
    G --> H[Provider Communication]
            
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#### Purpose of this set of slides

Communicate and discuss ICD-10 impacts, opportunities, and examples specific to SMA operations in the area of managed care.

#### Talking Points

- The move from ICD-9 to ICD-10 is a significant change for SMAs and unlike previous HIPAA efforts, ICD-10 impacts the business of Medicaid as much as its enabling technology systems.
- ICD-10's impact will be disruptive in the short-term, but positive over the longer term. The new code sets will benefit the delivery of care by indicating diagnoses and matching payment to care more precisely. In time, it will promote efficiencies and improvements in care documentation, claims processing, and business intelligence.
- CMS has prepared a series of slides and training materials especially for SMAs, which provide key information about the ICD-10 code sets, how to use them, how to benefit from them, and how to implement them.
- CMS hopes this information will assist SMAs with effectively implementing and benefiting from this major change to the specificity and content of codes sets used to categorize health care diagnoses and inpatient procedures.

#### Notes

- **Note:** the implementation of ICD-10 does not affect HCPCS codes (Levels I and II) for outpatient procedures except in cases where coverage and payment may be dependent on medical necessity as determined by diagnoses codes. For more info on HCPCS codes, please refer to: <http://www.cms.gov/medhpcpsgeninfo/>
- Unless otherwise specified in this presentation, ICD-10 refers to both ICD10-CM and ICD10-PCS.
- Unless otherwise specified in this presentation, the word "procedures" refers to inpatient procedures.



**AGENDA**

- Introduction
- Benefits of ICD-10
- ICD-10 Impacts
- Maintain Stability / Manage Change
- CMS Defined Services
- MITA Business Processes
- Impact to Payment
- SMA Programs and Services







1

Purpose: Introduce the discussion topics

Talking Points

- None



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Official CMS Codes, Approved for the ICD-10 Transition  
www.cms.gov/ICD10

## Benefits of ICD-10

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ICD-10 codes refine and improve SMA operational capabilities and processing. ICD-10 benefits include:

- Detailed health reporting and analytics: cost, utilization and outcomes;
- Detailed information on condition, severity, co-morbidities, complications and location; 
- Expanded coding flexibility by increasing code length to seven characters; and
- Improves operational processes across healthcare industry by classifying detail within codes to accurately process payments and reimbursements.

2

Purpose: To highlight some of the essential benefits of ICD-10; supports why the change is being made

Talking Points:

The ICD-9 code set is old, 33 years plus old. If you think about it in 1979 we would not be watching this via PowerPoint but paper only

No cell phones

No texting

No mute button

Consider the changes in healthcare – new conditions, new medical technology (i.e. MRI)

- Expands flexibility to update the codes as necessary due to the increase from a maximum of 4 or 5 characters to 7 characters. Each character in the 7 character ICD-10-PCS code identifies some aspect of the procedure such as ‘body system’, ‘root operation’, ‘body part’, or ‘surgical approach.’
- Enhances coding accuracy and specificity to classify anatomic site, etiology, and severity.
- Provides detailed information about the nature of a procedure performed in a hospital setting.

- 
- Provides detailed information about the location of the condition, severity, co-morbidities, complications, sequelae, and a variety of other important clinical parameters of conditions that are not supported in ICD-9-CM diagnosis codes.
- Improves operational processes across healthcare industry by classifying detail within codes to accurately process payments and reimbursements. In effect, accurate coding reduces the volume of rejected claims due to ambiguity. In addition, the detail embedded within ICD-10 codes informs healthcare providers and health plans of patient incidence and history, improving case management and care coordination.
- Allows the U.S. to compare health data across international borders to track and monitor the incidence and spread of disease and treatment outcomes at a higher category level.
- All of which allows for more accurate payment for new procedures and a better understanding of new procedures

 CMS ICD-10  
Official CMS website, resources for the ICD-10 Transition  
www.cms.gov/ICD10

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**ICD-10 Impacts**

3

Transition Slide – Impact of ICD-10 to core functions in SMA organization, to Claims and to providers

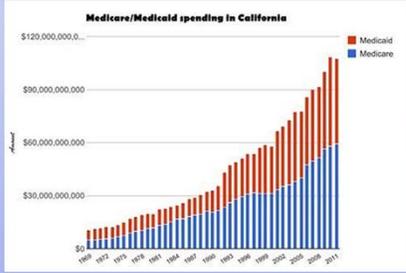


Official CMS Logo, Approved for ICD-10 Transition  
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## Impact to SMA

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- Claims Processing
- Information Technology
- Product Development
- Enrollment Management
- Reimbursement / Network Management
- Customer Service
- Care Management
- Quality Management
- Vendor Management

4

Purpose: To explain that ICD will impact nearly all core operations in your healthcare organization

Talking Points:

ICD-10 is a compliance effort that has a large impact on policies, business operations, clinical processes, and healthcare quality reporting. Preparing for ICD-10 will require an organization-wide approach and an understanding of all the areas impacted by its adoption.

### Claims Processing

Claims processing represents a major component of a Health Plan's core operations and administrative costs. The processing involves intake of claims through electronic and manual channels and adjudicating them through a series of multi-step processes with manual interventions that manage exceptions. Need to support reimbursement methodologies such as DRG/APC. SMA's will need to evaluate the entire claims business process to prepare to accept ICD-10 codes.

### Information Technology

ICD-10 will require significant modification to SMA MMIS systems, infrastructure and IVR equipment.

### Product Development

SMA will need to evaluate and reconfigure current benefit plan structures to identify the changes in plan elements and those that are more specific to diagnosis codes.

### Enrollment Management

SMA will need to evaluate enrollment process, applications and reports as they relate to information about conditions where ICD-9 codes are used.

### Customer Service

SMA should prepare for increased demand for customer service representatives, as well as additional training to respond to increased service calls. Representatives will need to know how to address potential migration issues with a mixture of old codes and new codes (i.e. wrong coding, rejected claims, etc.).

ICD-10 implementation planning process should involve a review of the look-up and search routines to identify potential modifications for new claims process and new medical coding. It is recommended that Management focus on inquiries and responses.

### Reimbursement Management

Medical coding plays a huge role in provider reimbursement and claims payment

### Care Management, Disease and Case Management

ICD-10 will have a significant impact on care management because of its dependence on diagnosis codes. SMA should evaluate every process as it relates to determining medical necessity, appropriateness of care, referrals, utilization, authorization and certification.

### Network Management, Provider Contracting, Network Management

SMA will have an opportunity to address the readiness of providers during re-contracting. ICD-10 codes will also provide payers opportunities to develop and implement new pricing and reimbursement structures, including fee schedules, and hospital and ancillary pricing scenarios that could take into account greater diagnosis-specificity.

### Quality Management

- Consider the impact to HEDIS measures (**HEDIS** (Healthcare Effectiveness Data and Information Set); a set of standardized performance measures for managed care

organizations; measures how many of a plan's enrollees are receiving care that meets national standards; many of the measures focus on preventive care, such as childhood vaccinations and mammograms and care for chronic illnesses, such as asthma or diabetes. ICD-10 codes from claims and encounter data are used to identify diagnoses and procedures for HEDIS reporting)

- SMA should consider the impact to any quality monitoring programs to oversee provider performance. This typically involves evaluating diagnostic and treatment codes to determine whether providers are performing adequately. SMA should evaluate their current measures and how the new codes affect those measures.
- Consider the additional information inherent in the new codes to determine how they can be used to improve the quality monitoring processes.

### Vendor Management

#### **Key is what tools/criteria will be used to determine vendor readiness; how will readiness be defined**

SMA's will need to collaborate with their vendors in order to effect a successful transition from the current ICD-9 state (and associated X12 4010 transaction sets) to ICD-10 (and its associated X12 5010 transaction sets)

To make sure vendors will be ready:

Identify all affected vendors and service/maintenance contracts. List the name of each vendor and the direct services it provides.

Review and maintain oversight of ongoing progress

Equally importantly is for the SMA to understand the technical component of vendor readiness depending on the type of vendor (e.g., behavioral health vendors paying provider claims to their contracted network, claims system vendors integrating a DRG grouper, medical management system vendors integrating the Milliman Care Guidelines or IT vendors

#### **(What tools/criteria will be used to determine vendor readiness; how will readiness be defined)**

SMA's depend on vendors for:

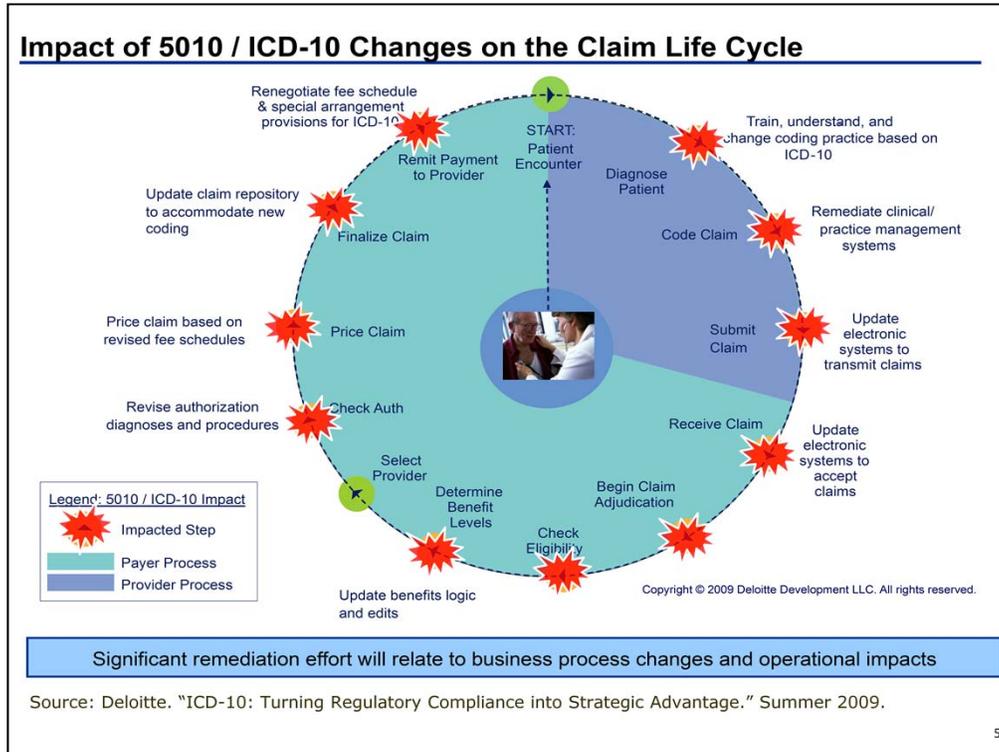
- Application support– determine if the vendor will continue to support the current application and if so when will changes be completed; when will testing occur; results of testing etc.
- Interoperability - Any software platform must be interoperable with other applications and have the capability to support multiple applications (this leverage is a critical component of any new application)
- Mapping and crosswalk rules/logic - SMA will want to review the ICD-10 codes selected to ensure that they agree with the vendor's ICD-10 choices. This is imperative so that claims pay correctly and medical management guidelines are not compromised
- Another reason that SMA's need to review mapping and crosswalk logic is because the

conversion is not a simple mapping process and SMA's need to be sure that mapping does not create benefit issues. (Example, a claims system may be set up to identify as a non-covered benefit a surgery billed with an ICD-9 diagnosis code for inactive Ménière's disease. Under ICD-10-CM, the codes for Ménière's disease do not delineate active or inactive. All of the associated ICD-10-CM codes would likely be covered under some clinical circumstances and it would be inappropriate to identify the surgery as a non-covered benefit without reviewing each individual medical record)

- Programming and testing – SMA's depend on their vendors to program and test ICD-10. SMA's will need to test with their vendors prior to "go live"; investment in test servers needs to be considered. In the event of third party tools, determine who should program and test
- Maintenance responsibilities - define maintenance responsibilities related to the various systems and what level of SMA input is needed

Items to consider:

- Determine whether the ICD-10 upgrade is covered under maintenance agreement.
- Determine vendor readiness and timelines for upgrading software to new coding systems and determine if upgrades are covered by any existing contracts.
- Create clinical and business scenarios and associated test data that will test vendor readiness in high risk areas



**Purpose of the slide**

Demonstrate the impact of ICD-10 by tracking the impacts through the life cycle of a claim.

**Talking Points**

- Receiving, adjudicating, and paying claims is a core function of health insurers.
- In addition, the use of claims information is used in various higher-level functions across other business areas (e.g. budgeting, rate setting, etc.).

**Notes**

- 5010 refers to the updated HIPAA standard ANSI x12 version 5010, which is required for electronic transactions by HIPAA covered entities as of 1/1/2012.



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## Impact To Claims

### Pre-Adjudication Edits

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- Eligibility Validation
- Code Validation
- Diagnosis Code Validation/DX and procedure tables



6

Purpose: To highlight some of the DX impact. To detail that by applying these edits / guidelines to claims prior to entering the adjudication system, errors may be spotted or eliminated before they are populated in downstream applications.

Talking Points:

**Any rules logic to ensue a clean before benefits are applied**

Business Rules

**Objective:** Discuss business requirements/business rules and the fact that they require review and update; emphasize claim adjudication rules

**Talking Points:**

Thoroughly review business rules related to clinical editing, claims adjudication, actuarial processes, fraud and abuse, care management etc.

Edits: Claim systems process claims using edits tied to specific codes

Re-evaluate these rules to determine how to re-code all of the current edits that are tied to ICD-9 codes

- Determine what they are
- How they are coded within the claim system

▪Impact of migrating to the ICD-10 codes

Recommend that time is spent re-evaluating each of the edits and not just map them to new codes

Some edits may (in some legacy systems) require re-programming the system as the edit could be “hard coded”

- We frequently hear that since entities don't code claims that the impact on transitioning to ICD-10 is “no big deal”. The fiscal agent has direct responsibility and SMA has indirect responsibility (if MMIS managed by a fiscal agent).
- Organizations should realize that diagnosis codes are the foundation of all the business processes within SMA. They impact medical policies, analytical categories and business rule policies.
- As business processes are impacted, the way the business processes are automated, executed and delivered through applications will also be impacted significantly
- Claims business processes and systems are highly dependent upon medical codes for processing
- Codes are used to determine whether services are covered, for benefit accumulation, and trigger logic within payor systems
- The logic represents business rules that are embedded into the system; purpose of these rules is to automate processing
- Even though SMA is not coding claims, decisions are required to modify the business processes that utilize DX codes. Who will make those decisions?

Member Validation – confirms presence of member record in our system

Validation Dates of Service – confirms that the claim date of service is valid and does not contain future date or a date outside of the member's eligibility date

Diagnosis Code Validation / ICD-10 Tables – confirms the presence and accuracy of DX and procedure codes, and all HIPAA code sets.



**Impact To Claims  
Adjudication**

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- Field and General Edits
- Member Eligibility
- Provider Eligibility and Status
- Prior-authorization
- Covered Services
- Pricing
- Potential Impact to Production




7

Purpose: To highlight the major steps in the adjudication process and the ICD-10 impact

Talking Points:

Claims must pass through a logical succession in the system in order to arrive at a pend, deny or paid status.

Business Rules

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**Field and General Edits:**

determines the validity of claim data (i.e. CPT/ICD9 codes; help to determine if fields are consistent with the business rules; federal regulations, age, gender, duplicate, and timely filing edits. Possible edits include but are not limited to:

- Procedure Code/ICD9: code inconsistent with member gender
- Procedure diagnosis code deleted, incomplete, or invalid
- Invalid type of bill.

**Member Eligibility:**

- Verifies that a member is eligible during the dates of service indicated on the claim
- Confirms coverage (verifies the receipt of premium payments from the state for the member for the coverage)
- Looks for Other Insurance

**Provider Eligibility and Status**

Edits include:

- Participating or nonparticipating status is verified
- The provider’s financial affiliation is determined
- Pending edits will apply if:
  - o The provider TIN or NPI is not on file

**Prior Authorization**

Determine if an authorization is required for the service rendered

Verifies the presence of a prior authorization; confirms that the dates of service are within authorization date

spans, limits etc. Examples of prior authorization edits include but are not limited to:

- Authorization is or is not on file
- Procedure does or does not match authorization
- Service has or has not exceeded the authorized limit.

**Covered Service** (is the member eligible for the service rendered)

Covered services are determined by eligibility, provider type, place of service, benefit management rules/limitations, valid procedure codes; code sets (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range;. This step determines if a member is eligible for the services rendered/ Edits include: Denial edit will apply if:

- o A service is not covered
- o A service has exceeded the benefit limit

**Pricing**

Claim is priced by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. Pricing edits may include:

- Appropriate COB and TPL rules for the specific health plan are in place to compute final provider payment
- If the provider is out-of-network, the appropriate fee schedule is applied
- When appropriate, pend queues are set up to review claims (by senior claims staff) to determine appropriate pricing, for example:
  - o First time claim submission from non-participating providers
  - o Claims that exceed high dollar billing thresholds.



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## Additional Claim Impacts To Consider

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- Claims processing during the transition period will require monitoring / Dual Processing
- Claim history will contain ICD-9 and ICD-10 codes; consider impact
- Applications used to look up claims may have to be modified
- Staff Training
- Update policies, manuals and procedures to accommodate ICD-10
- Develop workarounds



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Purpose: To take a closer view of the impact to Claims (SMA) business processes and systems.

Talking Points:

### Processing Claims During the Transition Period

SMA will need to develop processes and procedures for handling claims during the transition period. This includes the ability to process both ICD-9 and ICD-10 codes simultaneously

Identifying problems and developing procedures to address the them

### Applications

Applications used to look up claims will pull up the diagnosis codes. These applications will need to be modified to accept the larger field sizes of the ICD-10 codes and this is clearly a task of ACS.

But many of these applications have prompts or other supporting tools to help the user understand what they are reading (i.e. changes in code description displays (including fields, mouse-overs etc., number of supported codes per claim, conditional logic in the screen based on codes – consider granularity ICD-9 may not have included right vs. left but ICD-10 does so additional logic is needed, consider additional descriptive support for PCS specific definitions by character).

### Staff Training

Internal staff needs to understand the scope and complexity of the overall impact of ICD-10

- Customer Service teams
- QA teams – impact to reports and retrieving data
- EPSDT and HEDIS – do the reports from the MCO continue to make sense
- Claims Processors, Administrative Staff, I/S, Medical Review Staff, Actuaries, Auditors, Fraud Investigator

### Reference Documents

All reference documents need review to determine ICD-10 impact and update (i.e. claims processing manuals, provider manuals etc.)

### Updated Processes

As with any major implementation, staff needs to consider the need for workarounds to address issues/problems that fallout of mainstream processing

### Claim Edits

- There are edits that are linked to specific codes. edits are an example of the business rule logic built into claim systems SMA will need to re evaluate these edits to determine how they should be re-coded for ICD-10.

Consider that;

- The process will involve various business areas to review the business rules
- how they are coded into the edits within the ACS claim system
- how they rely on the ICD-9 codes and what the impact will be of migrating to the ICD-10 codes
- SMA should spend some time re-evaluating each of the edits and not just map them to new codes
- Who will make these decisions?

### Covered Service

- To evaluate whether a service is covered benefit tables are used to determined if covered under the program
- DX codes can also be used with the provider taxonomy to determine whether a provider can render the service the code describes
- DX codes can be used to determine whether a particular individual should be receiving the type of service rendered (e.g. OB/GYN services are not provided to a male member)
- This logic/rules will need to be modified within the system.

### Policy Remediation

- Medical policies, analytical categories and business rule policies will require remediation. This process is crucial to the organization. SMA want to ensure that after remediation the intent of the policy meets their need or is the same

### Claim History

What will be the impact to the process when benefit maximums, lifetime maximums or accumulators come into play?

What manual or systems processes will need to be made? Who will make those business decisions, SMA or ACS?

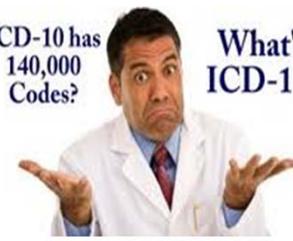


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## Are Providers Coding Correctly?

ICD-10 has 140,000 Codes?

What's ICD-10?



- Challenge of training billers and coders
- How will new requirements and documentation be met
- Are providers aware of SMA plan to comply with regulation

- Will provider staff use codes that are most familiar
- Consider effect if the incorrect code is utilized
- Will providers collect the appropriate information



Purpose: To explain that one of the biggest challenges that SMA as well as others payers face is “are providers coding correctly?” and paying correctly

#### Talking Points:

- Payers and providers are affected as they strive to streamline their operations, reduce costs and improve efficiencies.
- The initial point of contact is when a patient visits a provider. The provider collects information to diagnose the episode of illness. For this reason providers have a huge responsibility.
- Will the provider’s staff use the codes that they are most familiar to them? What will be the ripple effect when a claim is inadvertently submitted using a code in lieu of ICD-10? Providers need to be ready for this change.
- How will providers change the habits and attitudes already in place to work through errors and mitigate challenges without negatively impacting resources?
- What will be the impact to downstream processes

As a result, SMA could potentially experience the following:

#### Incorrect Codes on Claims (837 and paper) Received

Claims must have the correct codes in order to process appropriately. Question: have you thought about how you will address claims with incorrect codes i.e. ICD-10 code with DOS prior to 10/1, ICD-10 code with I9 claim type).

#### Potential Increased Error Rates As Providers Utilize Wrong Codes

- Different from claims submitted with old codes; represents the impact of providers submitting claims with incorrect codes.

- Potential of providers being either overpaid or underpaid. Underpaid providers will resubmit claims and/or complain. Overpayments cause payors to audit providers more closely and seek reimbursements. Either scenario will cause a claim that was previously adjudicated to be re-opened and reprocessed; re-work is costly
- SMA will perhaps implement workarounds to address these issues
- Some potential workarounds could include developing/creating new reports to identify problems and/or redundant processes to find and correct these errors.
- SMA may need to develop tools and strategies to assist providers with coding properly to reduce the possibility of increased errors
- Of importance will be the impact to smaller providers who may not have access to the type of staff training and automated tools that larger providers might use to prepare for this initiative

#### Retrain Staff on New Codes

- SMA staff will need to be retrained on reading and understanding the ICD-10 codes. Staff will need to understand ICD-10 to address/resolve provider coding issues.
- Who will train? Has any thought been given to designing, testing and implementing a training program?
- Consider that staff who had become familiar with the ICD-9 codes will have to start over with the ICD-10. Potentially there could be a loss of “institutional memory” (e.g. examiners who knew codes by heart will have to start over); may slow down processes

#### SMA Communication Plan with Providers

- SMA should develop a plan for communicating with providers on their implementation plans.
- SMA should offer a discussion of how their plans will impact the relationship with the providers; what activities the provider should expect to see and when.
- The most important impact will be how changes in the ICD Code Sets will affect provider contracts.
- SMA should communicate with providers so that they can implement methods/systems to avoid overpayments to providers; resolve any contractual issues (map ICD-9 to ICD-10) so they can make the contracts revenue neutral.



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## Vendor Support

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- Application Support
- Interoperability
- Programming and Testing
- Appropriate mapping and crosswalk programming
- Maintenance and Support



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**Objective:** In addition to having full knowledge of vendor readiness ( i.e., implementation plans, firm delivery dates, any associated risks, gap analysis describing tasks, dependencies), emphasize the need for SMAs to have knowledge of their technical needs from the various vendors.

**Talking Points:**

**Key is what tools/criteria will be used to determine vendor readiness; how will readiness be defined**

SMAs will need to collaborate with their vendors in order to effect a successful transition from the current ICD-9 state (and associated X12 4010 transaction sets) to ICD-10 (and its associated X12 5010 transaction sets)

To make sure vendors will be ready:

Identify all affected vendors and service/maintenance contracts. List the name of each vendor and the direct services it provides.

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**(What tools/criteria will be used to determine vendor readiness; how will readiness be defined)**

SMAs depend on vendors for:

- Application support– determine if the vendor will continue to support the current application and if so when will changes be completed; when will testing occur; results of testing etc.
- Interoperability - Any software platform must be interoperable with other applications and have the capability to support multiple applications (this leverage is a critical component of any new application)
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- Another reason that SMA's need to review mapping and crosswalk logic is because the conversion is not a simple mapping process and SMA's need to be sure that mapping does not create benefit issues. (Example, a claims system may be set up to identify as a non-covered benefit a surgery billed with an ICD-9 diagnosis code for inactive Ménière's disease. Under ICD-10-CM, the codes for Ménière's disease do not delineate active or inactive. All of the associated ICD-10-CM codes would likely be covered under some clinical circumstances and it would be inappropriate to identify the surgery as a non-covered benefit without reviewing each individual medical record)
- Programming and testing – SMA's depend on their vendors to program and test ICD-10. SMA's will need to test with their vendors prior to “go live”; investment in test servers needs to be considered. In the event of third party tools, determine who should program and test
- Maintenance responsibilities - define maintenance responsibilities related to the various systems and what level of SMA input is needed

Items to consider:

- Determine whether the ICD-10 upgrade is covered under maintenance agreement.
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**Maintain Stability / Manage Change**

11

Transition Slide – Managing Change



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## Key Performance Indicators

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- Accurate and timely payments in a manner consistent with mandated requirements for contested and uncontested claims.
- First pass rate is monitored
- Monitor customer service metrics
- Action plans in place to effect an increase in electronic; decrease paper submissions
- Defined process and evidence of regular oversight / quality assurance audits for the department
- Appropriate dispute resolution mechanisms in place
- Monitor denials vs. paid vs. pend



Key Performance Indicators  
and why you need them...  
no. 100...



12

Purpose of Slide: To discuss some of the benchmarks used to measure and track performance.

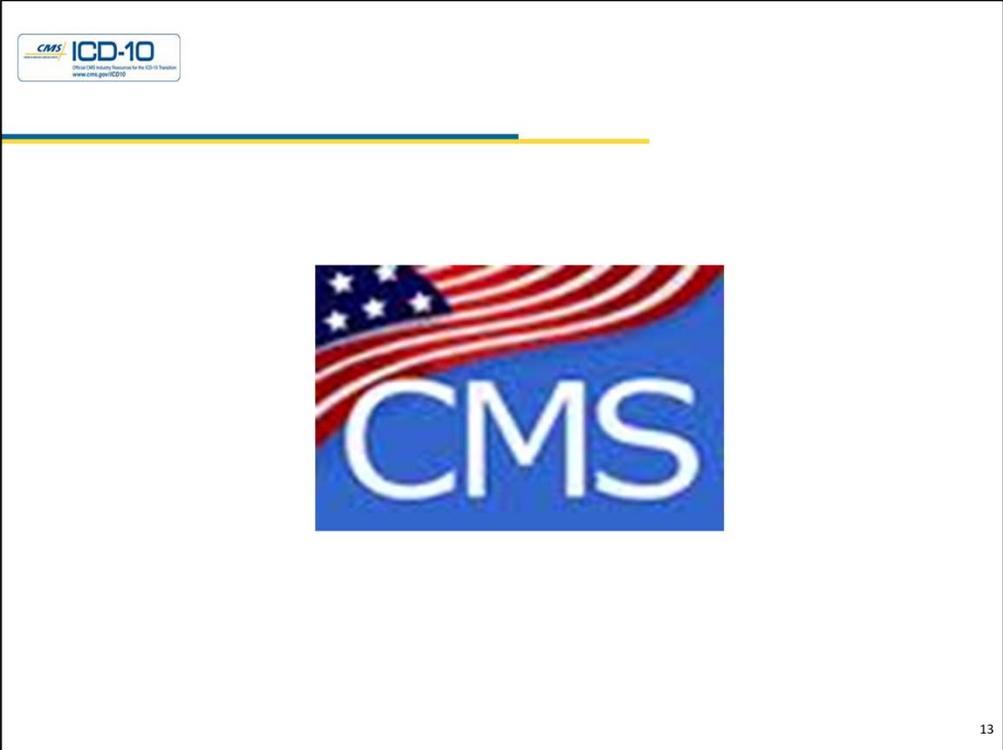
#### Talking Points:

These benchmarks can be used to monitor performance in the pre ICD-10 environment and the post ICD-10 environment

KPIs are frequently used to evaluate successes or failures

Choosing KPI's depends on what is important to the SMA

Timely and accurate claims processing (includes reports and IT systems are in place to effect timely and accurate processing, appeals are handled appropriately and consistent with statutory requirements)



Title Page



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## CMS Defined Code Sets

- Third Party Liability (TPL)
- Hysterectomy, Abortion, Sterilization (HAS)
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)



The Great Seal of the State of California, featuring a woman holding a torch and a grizzly bear, with the text 'THE GREAT SEAL OF THE STATE OF CALIFORNIA' and 'EUREKA'.



A 3D stick figure holding a ball, symbolizing a player or participant.

14

Purpose: To highlight the CMS services

Talking Points:

CMS needs to use as well

CMS to provide guidance; States ultimately responsible for their identification of the codes



## COB / Third Party Liability

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What will be the impact of ICD-10 considering that Medicaid is payer of last resort?

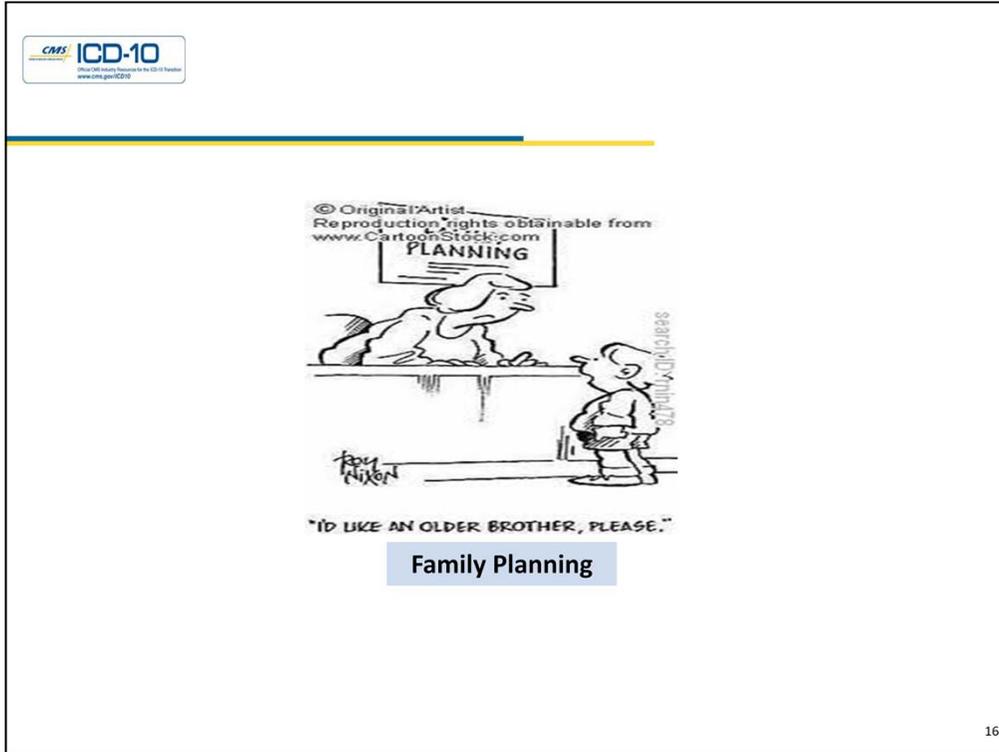
- Impact when entity is a non HIPAA compliant entity
- When primary entity has processing rules (i.e. services span the compliance date, difference in “from date and through date rules” etc.)
- Differences in mapping rules

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Purpose: Discuss the impact of ICD-10 on TPL

Talking Points:

- Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay all or part of the cost of the recipient’s medical care. If the
- recipient has other coverage through a TPL source, the provider must bill the TPL source prior to billing / Medicaid is the payer of last resort.
- If pay-and-chase, other insurance processing rules.
- Consider impact to Workers’ Compensation cases



Title Page

Impact of ICD-10 to the Family Planning Benefit.

 <b>EPSDT – Annual Report CMS 416</b>		
Report Need	CPT Code	ICD-9 Code Accompanying
Inclusion	83655 Blood lead test	V15.86, V82.5
Exclusion	83655 Blood lead test	984(.0-.9), e861.5
ICD-9 Code		ICD-10 Code
V15.86 Personal history of contact with and (suspected) exposure to lead		Z77.011 Contact with and (suspected) exposure to lead
V82.50 Screening for chemical poisoning and other contamination		Z13.88 Encounter for screening for disorder due to exposure to contaminants
984.0 Toxic effect of inorganic lead compounds		T56.0X1A Toxic effect of lead and its compounds, accidental (unintentional), initial
E861.5 Accidental poisoning by lead paints		No ICD-9-CM code(s) convert to ICD-10-CM E861.5

Purpose: To highlight the impact of ICD on the EPSDT reporting.

Talking Points:

- These are examples /illustrations of mapping challenges. They do not include all the potential matches. For instance, 984.0 actually maps to 12 ICD-10 codes.
- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program.
- The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services.
- The completed report demonstrates SMA' attainment of its participation and screening goals.
- Lawsuits have been filed in at least 28 states alleging the states had failed to adequately provide EPSDT services.

Purpose: To discuss CMS 416 reporting criteria

Talking Points:

- Line 14 -- Total Number of Screening Blood Lead Tests -- Enter the total number of screening blood lead tests furnished to eligible individuals from line 1a under fee-for-service or managed care arrangements. Follow-up blood tests performed on individuals who have been diagnosed

with or are being treated for lead poisoning should not be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:

- 1) Count the number of times CPT code 83655 (“lead”) for a blood lead test is reported within certain ICD-9-CM codes (see Note below); or
- 2) You may include data collected from use of the HEDIS®1 measure developed by the National Committee for Quality Assurance to report blood lead screenings if your State had elected to use this performance measure.

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5 (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984(.0-.9) (toxic effect of lead and its compounds) or E861.5 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted

- **CPT-4 codes: Evaluation and Management Codes \*\***

99202-99205 New Patient 99213-99215 Established Patient

\*\* These CPT-4 codes must be used in conjunction with codes **V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-70.9.**

Consider the changes to the V codes based on ICD-10

#### MICC

Provides case management for high risk pregnant women and infants up to age two. From a reporting perspective, those specifications will need to be modified to include ICD-10

 **Introducing Medicaid Information Technology Architecture (MITA) 3.0**

- Web-based access and integration
- Software reusability
- Use of commercial off-the-shelf (COTS) software
- Integration of public health data



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Purpose: To introduce MITA 3.0

Talking Points:

ICD-10 impacts to some of the MITA business process

 **Operations Management** 

<b>Business Processes</b>	<ul style="list-style-type: none"> <li>• Price Claim/Value Encounter*</li> <li>• Edit Claim/Encounter*</li> <li>• Audit Claim Encounter*</li> <li>• Apply Mass Adjustment*</li> <li>• Prepare Home Community Based Service (HCBS) payment (if adjudicated in the same manner as regular claims)*</li> <li>• Prepare COB</li> </ul>
<b>Data Structure Updates</b>	<ul style="list-style-type: none"> <li>• Expand the claims record to store the longer ICD-10 codes</li> <li>• Expand the encounter record to store the longer ICD-10 codes</li> <li>• Expand the claims record to store additional occurrences of ICD-10 codes</li> <li>• Expand the encounter record to store additional occurrences of ICD-10 codes</li> <li>• If utilized, expand the ICD-10 field in the “store and forward repository”</li> <li>• For mainframe environments, may need to utilize filler or expand the copybook layout to accommodate longer ICD-10 codes</li> <li>• Expand both the claim and encounter record to store qualifiers for ICD-10 and ICD-9-CM codes</li> </ul>
<b>Inbound System Interfaces</b>	<ul style="list-style-type: none"> <li>• Update the EDI translator to accept ICD-10 codes on 837I (Inpatient claim), 837P (Professional claim), 837 (Dental claim) claim transactions, also NCPDP claims and prior authorization interfaces</li> <li>• If utilized, update the interface to write EDI transactions to a store and forward repository</li> <li>• Update the interface between the EDI translator and claims adjudication module to exchange ICD-10 codes</li> <li>• Update imaging system that scan paper claims</li> </ul>

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**Purpose of the slide**

To explain some of the ICD-10 impacts to operations management business and system requirements

**Talking Points:**

None



# Operations Management



User Interfaces

- Update Claims / Encounter data entry screens to accept ICD-10 codes
- Update user applications / look-up screens

Business Rules and Edits

- Update X12 Implementation Assistance Handbook edits that use ICD-10 codes
- Database that stores a snapshot of the EDI transactions submitted by providers. Some health plans use these to assist in responding correctly on outbound EDI response transactions to providers.
- Update Medicare Severity (MS) Diagnosis Related Groups (DRG) (e.g., grouper software) for hospital claims and ambulatory payment processes.
- Develop a solution for processing claims/encounters when the dates of service span the compliance date (e.g., instances where the prior authorization spans the compliance date)
- Update any systems processing that uses ICD-9-CM codes in claims adjudication. Possible uses of ICD-10 codes include the following: Automated Medical Review, Manual Medical Review, Pre-Payment and Post Payment Fraud Edits, Claims Grouping, Update Medicaid code editor, Update MS Diagnosis Related Groups (DRG) (grouper software) for hospital claims and ambulatory payment processes, Claims Pricing, Prior Authorization Verification, Benefit Utilization Checking, COB and TPL Identification
- Update MS Diagnosis Related Groups (DRG) (grouper software) for hospital claims and ambulatory payment processes
- Develop a solution for utilizing historical ICD-10 data that precedes the compliance date (e.g., utilization checking)
- Develop a solution for processing claims/encounters when the dates of service span the compliance date

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**Purpose of the slide**

To explain some of the ICD-10 impacts to the MITA operations management business requirements.

**Talking Points:**

Speak to bulleted items in chart

Update any systems processing that uses ICD-9-CM codes in claims adjudication. Possible uses of ICD-10 codes include the following:

- Automated Medical Review
- Manual Medical Review
- Pre-Payment and Post Payment Fraud Edits
- Claims Grouping
- Update Medicaid code editor

Update MS Diagnosis Related Groups (DRG) (grouper software) for hospital claims and ambulatory payment processes

- Claims Pricing
- Prior Authorization Verification
- Benefit Utilization Checking
- COB and TPL Identification

Update Medicare Severity (MS) Diagnosis Related Groups (DRG) (e.g., grouper software) for hospital claims and ambulatory payment processes.

While the MS DRG grouper is not used for ambulatory claims, states may use Ambulatory Patient Groupers (APG) or Ambulatory Payment Classification (APC) or other groupers

 **Operations Management** 

**COB Business Rules and Edits**

- Update edits that identify COB cases during claims processing
- Develop a solution for utilizing historical ICD-10 data that precedes the compliance date
- Develop a solution for utilizing / determining mapping or matching of ICD-9-CM with ICD-10 so that there is correlation between old claims and new claims for the same case and / or episode of illness
- Update the process to support the maintenance of historical data on TPL resource records
- Update the process to identify / flag trauma diagnosis

**COB Business Rules and Edits**

- Update 837 COB transaction to transmit claims to Trading Partners. This includes developing a solution for non-covered entity trading partners (e.g., auto insurance) that still use ICD-9-CM codes

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**Purpose of the slide**

To explain some of the ICD-10 impacts to the MITA operations management business requirements.

**Talking Points:**

Speak to bulleted items in chart

 **Operations Management** 

**Reports**

- Update reporting that includes ICD-10 codes.

**Outbound System Interfaces**

- Update claims extract for Decision Support System (DSS)
- Update the interface between the claims adjudication subsystem and the EDI Translator to exchange ICD-10 codes.
- Update the EDI translator to send 835 claims responses with ICD-10 codes.

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**Purpose of the slide**

To explain some of the high impact operations management business requirements, the ICD-10 testing impact, and the level of testing required

**Talking Points:**

None

 **Financial Management** 

<b>Business Processes</b>	<ul style="list-style-type: none"> <li>• Manage TPL Recovery</li> </ul>
<b>Business Rules and Edits</b>	<ul style="list-style-type: none"> <li>• Update edits that identify COB cases during claims processing</li> <li>• Develop a solution for utilizing historical ICD-10 data that precedes the compliance date. Develop a solution for utilizing/determining mapping or matching of ICD-9-CM with ICD-10 so that there is correlation between old claims and new claims for the same case and/or episodes of illness</li> <li>• Update the process to support the maintenance of historical data on TPL resource records</li> <li>• Update the process to identify/flag trauma diagnosis</li> </ul>
<b>Outbound System Interfaces</b>	<ul style="list-style-type: none"> <li>• Update 837 COB transaction to transmit claims to Trading Partners. This includes developing a solution for non-covered entity trading partners (e.g., auto insurance) that still use ICD-9-CM codes.</li> </ul>

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**Purpose of the slide**

To explain some of the high impact operations management business requirements

**Talking Points:**

None

**CMS ICD-10**  
Official CMS Website, Transition to the ICD-10 Timeline  
www.cms.gov/ICD10



**Impact to Payment**



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Transition Slide



**CMS ICD-10**  
Official Medicare Reimbursement for ICD-10 Coding  
[www.cms.gov/ICD10](http://www.cms.gov/ICD10)

# Diagnosis-Related Groups (DRGs)

## The Basics

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- DRGs attempt to align actual payment to expected costs by bundling a set of services over a period of time for patients with similar resource intensity and clinical coherence.
- Additionally, DRGs attempt to adjust payments for cost factors outside of a provider's control (e.g. inflation and geographic variation in wage rates)
- The assignment of DRGs and determination of relative payment weight is heavily dependent on inpatient procedures and diagnoses



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Purpose: Introduce the basics of diagnosis related groups (DRGs).

#### Talking Points

- There are different four major versions of DRGs in use:
  - Classic CMS DRGs (no longer in use by CMS)
  - Medicare Severity DRGs (MS-DRGs)
  - All-Patient DRGs (AP-DRGs)
  - All-Patient Refined DRGs (APR-DRGs)
- The classic CMS DRGs (prior to FY2008) and MS-DRGs (FY2008+) are used by the Centers for Medicare and Medicaid Services for hospital payment for Medicare beneficiaries. Since these DRGs are based on Medicare data, other payers sought groupers more specific to their populations.
- AP-DRGs are an expansion of Medicare's DRGs to be more representative of non-Medicare populations such as pediatric patients.
- APR-DRGs incorporate severity of illness subclasses into the AP-DRGs.

#### Notes

- Source: 3M APR DRG Classification System: Methodology Overview (Version 26.1). Accessed on 09/13/11. [http://www.hcup-us.ahrq.gov/db/nation/nis/v261\\_aprdrg\\_meth\\_ovrview.pdf](http://www.hcup-us.ahrq.gov/db/nation/nis/v261_aprdrg_meth_ovrview.pdf)
- Source: CMS. "Acute Care Hospital Inpatient Prospective Payment System: PAYMENT SYSTEM FACT SHEET SERIES." November 2010. Accessed 09/13/2011. <https://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsh.pdf>



## Diagnosis-Related Groups (DRGs)

Moving from ICD-9 to ICD-10

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- DRGs are based on an analysis of historical information and are typically licensed and maintained by an entity who is responsible for their updates and revisions
  - But there are no historical information yet for ICD-10
- In order to create DRGs for ICD-10, maintainers use clinical and/or probabilistic maps (e.g. CMS' Reimbursement Map) to use historical ICD-9 data for developing ICD-10 groupers
- The only ICD-10 grouper that has been publically specified for public review and comparison is the MS-DRG (v26+)
- Maintainers attempt to make ICD-10 groupers 'financially neutral' but this assumes coding conventions will be similar across two very different code sets

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Purpose: Introduce the basics of diagnosis related groups (DRGs).

### Talking Points

- The short-term financial implications of ICD-10 are unclear
- In a recent paper by 3M, it found:
  - "The transition from the ICD-9-CM version of the MS-DRGs to the ICD-10 version of the MS-DRGs will have a minimal impact on the aggregate payments to hospitals (+0.05%) and on the distribution of payments across hospital types (-0.01% to 0.18%)."
  - 3M notes in the paper that it does not account for the learning curve and additional specificity required by the new code sets
- Truth is, nobody knows whether DRGs will be financially neutral regarding ICD-10 until there is enough experience and data.

### Notes

- Source: Mills, R., R Butler, et al. "Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments." MMRR 2011. 2 (2).
- Source: CMS. Converting MS-DRGs 26.0 to ICD-10-CM and ICD-10-PCS. Accessed 09/13/2011. [https://www.cms.gov/ICD10/17\\_ICD10\\_MS\\_DRG\\_Conversion\\_Project.asp](https://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp)



**ICD-10**  
Official ICD-10 Codes, Instructions for Use (2011) Replaces  
www.cms.gov/ICD10

## Diagnosis-Related Groups (DRGs)

Unintended Consequence

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■ A 50 year old woman with rheumatoid arthritis is admitted for a right total hip replacement. Patient is noted to have respiratory failure as a secondary diagnosis at the time of discharge, but this was not primary reason for hospitalization.

<p style="text-align: center; font-weight: bold; font-size: 0.8em;">ICD-10 procedure: 0SR90JZ – Replacement of right hip joint w synthetic substitute, open approach</p>	<p>M05651 Rheumatoid arthritis of right hip w involvement of other organs/systems J9690 Respiratory failure, unspec, unspec whether hypoxia or hypercapnia</p>	<p style="text-align: center; font-weight: bold; font-size: 0.8em;">DRG 469 Major joint replacement or reattachment of lower extremity w/ MCC <b>weight 3.4724 (\$19,390)</b></p>
<p style="text-align: center; font-weight: bold; font-size: 0.8em;">ICD-10 procedure: 0SR90JZ – Replacement of right hip joint w synthetic substitute, open approach</p>	<p>M05651 Rheumatoid arthritis of right hip w involvement of other organs/systems J9610 Chronic respiratory failure, unspec whether hypoxia or hypercapnia</p>	<p style="text-align: center; font-weight: bold; font-size: 0.8em;">DRG 470 Major joint replacement or reattachment of lower extremity w/o MCC <b>weight 2.1039 (\$11,748)</b></p>

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Purpose:

Provide of how the same procedure may have very different payment under ICD-10 than in ICD-9.

Talking Points

- In this case, the additional specificity in ICD-10 provides for lower payment.
- Though this is an example of where a similar procedures receives less payment in ICD-10, there are also examples where similar procedures receive more payment in ICD-10.

Notes

- All dollar amounts assume a base rate of \$5584.12 applied to v28.0 MS-DRG weight (FY2011). [Source: CMS Acute Inpatient Home Page. Accessed 11/01/11.  
<https://www.cms.gov/AcuteInpatientPPS/FR2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250520&intNumPerPage=10>
- ICD-10 grouping is from CMS' v28.0 R1 grouper and also CMS' Draft ICD-10 MS-DRG 28.0 R1 definitions manual at: [https://www.cms.gov/icd10manual/definitions\\_manual/p0001.html](https://www.cms.gov/icd10manual/definitions_manual/p0001.html)
- Other Sources:
  - CMS. "Converting MS-DRGs 26.0 to ICD-10-CM and ICD-10-PCS. Accessed 09/13/2011.  
[https://www.cms.gov/ICD10/17\\_ICD10\\_MS\\_DRG\\_Conversion\\_Project.asp](https://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp)
  - Source: R Butler and J Bonazelli. "Converting MS-DRGs to ICD-10CM/PCS: Methods Used, Lessons

Learned." Journal of AHIMA. December 2009. Accessed 09/13/2011. <http://journal.ahima.org/wp-content/uploads/JAHIMA-converting-I10.pdf>

- CMS. "Version 28.0 ICD-10 MS-DRGs Update." Accessed 09/13/2011. <https://www.cms.gov/ICD10/Downloads/V28MsdrgUpdate.pdf>



Title Page – supports the following sections

Mention Policy Briefs and Clinical Documentation to help States with translating codes and understanding the new concepts in ICD-10

Policy Briefs – Completed – Pregnancy, Children’s Health Insurance Program (CHIP), HIV/AIDS, Breast and Cervical Cancer

In development – Spinal Cord Injury, High Risk Pregnancy, Autism

Clinical Documentation – Breast Cancer, Acute Myocardial Infarction, Diabetes Mellitus Type 2



**CMS ICD-10**  
Office of Information Systems and Technology  
www.cms.gov/ICD10

# Discussion

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To Think About...

- **How are you addressing the manual processes / requests for additional information?**
  - Has that process worked effectively in the past?
  - Based on discussions at your SMA, the workshop and our discussions, are changes to that process required as a result of ICD-10 remediation?
- **How are you addressing claims that you have flagged to pend?**
- **Are there best practices from prior system modifications that you can use during the ICD-10 transition?**
  - Are there practices that you know will not work?



Discussion

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### Purpose of Slide:

Generate discussion amongst participants regarding implementation lessons learned, and Make the overview discussion more interactive

### Talking Points:

Points for discussion:

- Lessons learned from policy, processes, and systems modifications
- Lessons learned from establishing governance structures and sharing project management tools
- Lessons learned from Coordination within the SMA and industry workgroups that can be shared with other SMAs
- How are SMAs coordinating ICD-10 activities with efforts driven by other Federal and State regulations
- Code freeze discussion
  - Various stakeholders in the industry have commented that the constantly moving target of changes in ICD-10 and GEM between now and the implementation date has added complexity to the transition process.
  - A request to limit changes was heard by CMS and NCHVS who responded with an approach to limiting these changes prior to implementation. This approach for limiting these changes is noted in this slide

 **ICD-10**  
Official ICD-10 Codes, Approved for the 2013 Year  
www.cms.gov/ICD10

# Questions

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