



CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

MITA and ICD-10 Support
National Quality Strategy

↓

ICD-10 Overview

↓

Analytics and Reporting

↓

Program Integrity

↓

Policy Remediation Best Practices

↓

Managed Care

↓

Claim Management

↓

Provider Communication

California ICD-10 Site Visit

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

ICD-10 Overview

June 10-11, 2013

Purpose of this set of slides

XXX

Talking Points

- XXX
- XXX

Notes

- XXX



Agenda

- What is ICD-10?
- Nature of Changes
- Why should I Care?
- Coding Challenges
- Mapping Challenges
- Code aggregation – Impacts to the business
- Analytics Challenges
- Benefits and Advantages of ICD-10
- Questions and Discussion



ICD-10
Official ICD-10 Release Document for the ICD-10 Transition
www.cms.gov/ICD10

What is ICD-10?

Some ICD-10 Basics

In 1990, the World Health Organization (WHO) approved the 10th Revision of the International Classification of Diseases (ICD), which is known as ICD-10.

What	Why	When
<ul style="list-style-type: none"> • According to the WHO, ICD-10 is “the international standard diagnostic <u>classification</u> for all general epidemiological, many health management purposes and clinical use.” • In the U.S., ICD-10 includes: <ul style="list-style-type: none"> ➢ ICD-10-CM : clinical modification of WHO standard for diagnoses that is maintained by NCHS and is for specific use in the U.S. ➢ ICD-10-PCS: inpatient procedures developed and maintained by CMS 	<ul style="list-style-type: none"> • ICD-10-CM and PCS are complete revisions of their U.S. developed ICD-9 counterparts, which were adopted in 1979 <ul style="list-style-type: none"> ➢ More information per code ➢ Better support for care management, quality measurement, & analytics ➢ Improved ability to understand risk and severity 	<ul style="list-style-type: none"> • Compliance Date: 10/1/14 <ul style="list-style-type: none"> ➢ Outpatient services are based on the Date of Service ➢ Inpatient services are based on the Date of Discharge <div style="text-align: center; margin-top: 10px;">  </div>
Who		
	<ul style="list-style-type: none"> • All HIPAA-covered entities must use ICD-10 for information they transmit electronically 	

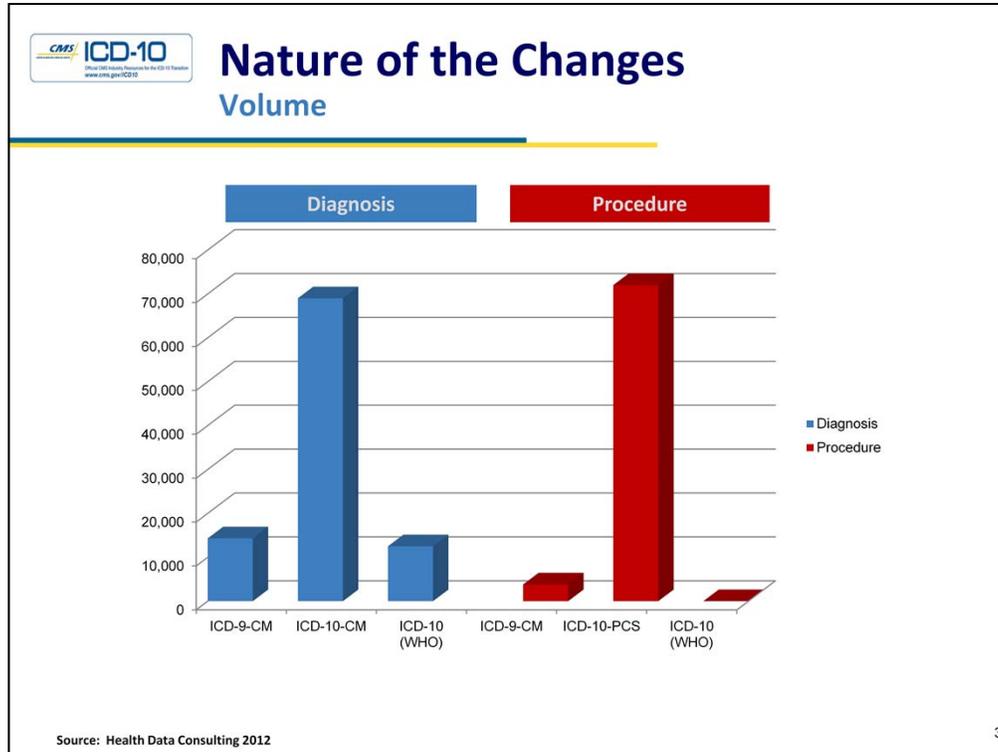
2

Purpose of the slide

To answer some of the basic questions about ICD-10: what, why, who, and when.

Talking Points

- Note that ICD-10 has been used for mortality reporting in this country since 1999

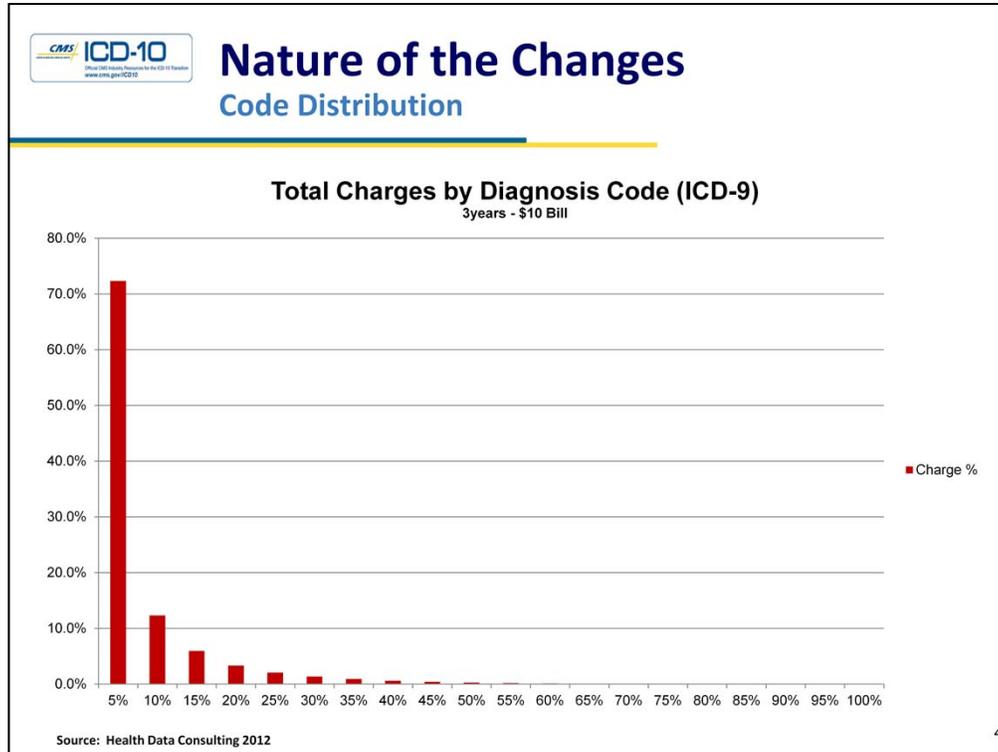


Purpose of the slide:

This graphically illustrate the difference in volume of code between 9, 10 and the WHO

Talking Points:

- Significant changes in the number of codes but more importantly big changes in structure and definition of the codes
- ICD-10 international version is less than the current ICD-9-CM diagnosis codes
- Point out that diagnosis and procedure codes are very different standards and really only share the ICD-10 prefix but otherwise don't have much in common
- There is no international version of ICD-10-PCS codes
- These codes are only used for inpatient procedures and will not be used for outpatient or professional procedures or services

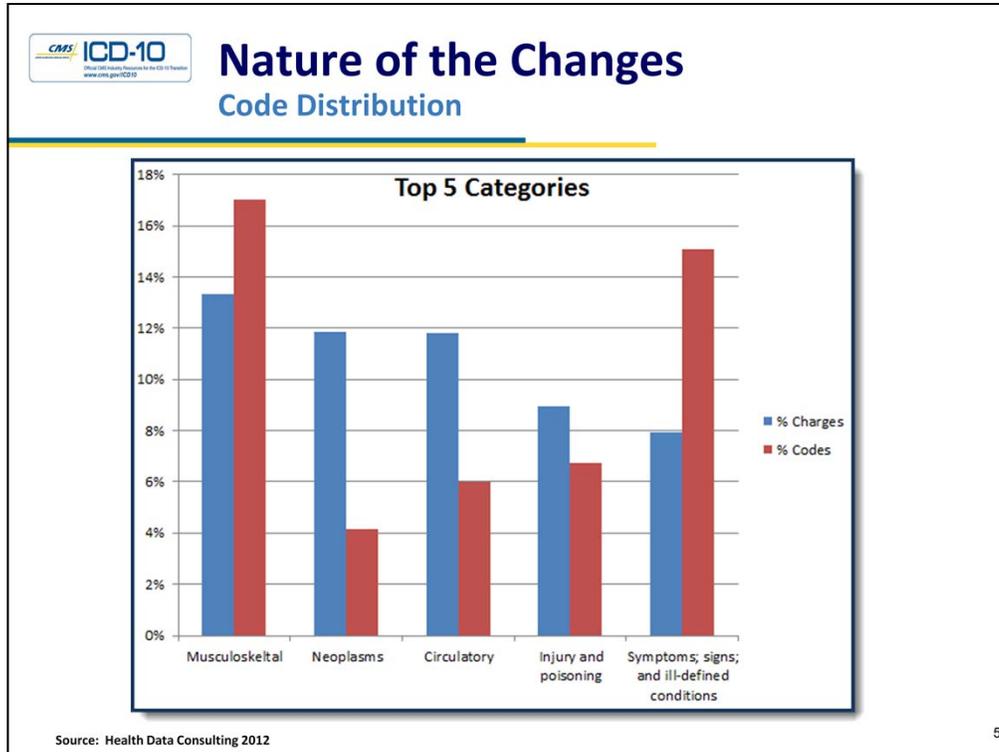


Purpose of the slide:

Illustrate the distribution of codes by volume. Each bar represents 5% of the codes that relates to the percent of charges.

Talking Points:

- This was based on an analysis of ICD-9 codes for all claim types for all programs for a set of payer data over 3 years covering ~ 1 million lives
- Demonstrate that a relatively small percent of the codes account for a large percentage of the charges.



Purpose of the slide:

Illustrate the distribution of codes by large categories based on both dollars and volume

Talking Points:

- This was based on an analysis of ICD-9 codes for all claim types for all programs for a set of payer data over 3 years covering ~ 1 million lives



Official ICD-10 Coding System for the ICD-10 Transition
www.cms.gov/ICD10

Nature of the Changes

Diagnosis Codes – Clinical Example

A patient is admitted as the result of [rupture of the cardiac wall without bleeding into the pericardium]. The patient is [within 4 weeks] of a [myocardial infarction].

ICD9 Code	Description
42979	<i>Certain sequelae of myocardial infarction, not elsewhere classified, other</i>
ICD10 Code	Description
I233	<i>Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction</i>

Source: Health Data Consulting 2012
6

Purpose of the slide:

This illustrates the best ICD-9 code and the best ICD-10-CM code to represent this clinical scenario. This slide focuses on ICD-9

Talking Points:

- These two slides illustrate the difference in the content of ICD-9 as compared to ICD-10 for the same clinical scenario. In ICD-9 we can only capture that there was some sequelae of a heart attack



Official ICD-10 Coding System for the ICD-10 Revision
www.cms.gov/ICD10

Nature of the Changes

Diagnosis Codes – Clinical Example

A patient is admitted as the result of [rupture of the cardiac wall without bleeding into the pericardium]. The patient is [within 4 weeks] of a [myocardial infarction].

ICD9 Code	Description
42979	<i>Certain sequelae of myocardial infarction, not elsewhere classified, other</i>

ICD10 Code	Description
I233	<i>Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction</i>

Source: Health Data Consulting 2012
7

Purpose of the slide:

Same as the prior slide, but this is focused on the best ICD-10-CM code for this clinical scenario.

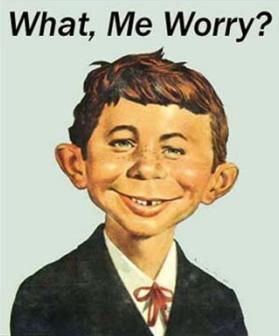
Talking Points:

- As illustrated in the bracket ins Red, in addition to the concept of a sequelae of a heart attack, we can also capture that there was a rupture of the cardiac wall, but not bleeding into the lining of the heart and that this occurred with 4 weeks of the heart attack.



Why Should I Care?
"Top Ten Reasons"

What, Me Worry?



1. **It's the law**
2. **Budget uncertainty**
3. **Provider relations**
4. **Program integrity**
5. **Analytic uncertainty**
6. **Major policy and rule re-write**
7. **Unpredictable DRG Assignment**
8. **Changes to quality measures**
9. **Potential mandate changes**
10. **Unpredictable contract changes**

8

Purpose of the slide: Illustrate some of the key business reasons that executives, directors, managers and all aspects of the organization should care about the implementation of ICD-10

Talking Points:

1. It's the law
 - It's the law. No payment for claims with ICD-9 codes with dates of service or discharge dates after Oct 1 2014
2. Budget uncertainty
 - Uncertainty about the extent of the remediation effort
 - Changes in definition of case mix
 - Lack of historical experience in projecting trends
 - Potential change in the definition of population and disease related coverage
 - Unanticipated result of edits
3. Provider relations
 - Confusion in reporting
 - Delays in payment
 - Provider education
 - Changes in payment policies

4. Program integrity
 - Identification of the appropriate service for the appropriate condition will be based on entirely different logic
5. Analytic uncertainty
 - Categories of services and conditions will be completely redefined.
6. Major policy and rule re-write
 - All policies that reference patient conditions or institutional procedures will require a complete re-write and testing
7. Unpredictable DRG assignment
 - Dramatic changes in coding and terminology (particularly with the PCS codes) along with the wide range for coding options mean potential significant variability in DRG assignment.
 - For payers using crosswalks and then applying their own groupers, DRG assignment is even less predictable
8. Unpredictable quality measures
 - Redefinition of quality measure numerator and denominator criteria to support ICD-10 and variability in coding practices will make quality measures and performance trips highly variable and of questionable validity
9. Potential mandate changes
 - Mandates for program eligibility, payment, privacy and security and other condition based mandates will potentially be defined quite differently in ICD-10
10. Unpredictable contract changes
 - Case rates, disease management programs and a variety of other contract related issues where diagnosis or procedure codes play a role will be significantly different under ICD-10 with little historical information to guide contract evaluation and negotiation

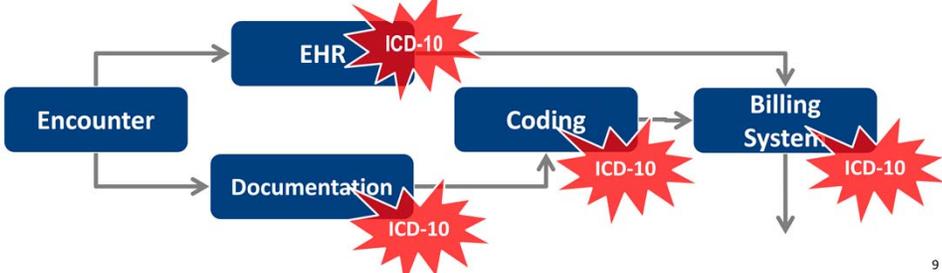


ICD-10
Official ICD-10 Coding System for the ICD-10 Transition
www.cms.gov/ICD10

Upstream Impacts

(Providers and Practitioners)

- **Documentation** – organized textual description of a medical encounter, which may include complaint, history and physical, assessment and plan, orders, medications, lab results, etc.
- **Terminology** – computer processable way to index, store, retrieve, and aggregate clinical data across specialties and sites of care
- **Classification** – aggregation of descriptions of medical diagnoses and procedures into universal codes primarily for use with reimbursement, decision-support, and analytics and reporting



```

graph LR
    Encounter[Encounter] --> EHR[EHR]
    Encounter --> Documentation[Documentation]
    EHR --> Coding[Coding]
    Documentation --> Coding
    Coding --> Billing[Billing System]
    EHR -.-> Billing
  
```

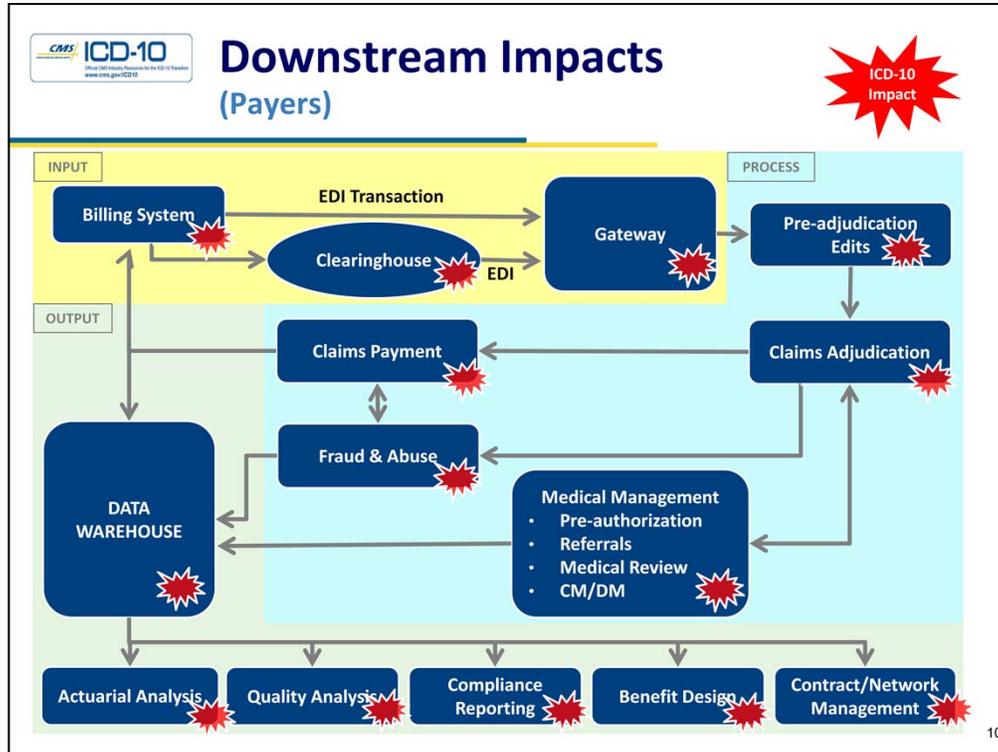
9

Purpose of the slide

Describe the upstream impacts of ICD-10 at the point of care and discuss the difference between documentation, terminology, and classification.

Talking Points

- One of the biggest challenges of ICD-10 is at its source - the point of care.
- The American Association of Professional Coders (AAPC) provides excellent presentation of ICD-10 impacts on typical providers/practitioners at <http://www.aapc.com/ICD-10/resources.aspx/>
- With the EHR Incentive Program, health system development (e.g. medical homes and accountable care organizations), ICD-10, HIPAA "two," and other initiatives, providers and practitioners are seeing the largest change in the way they do business in most of their lifetimes.



Purpose of the slide

Describe the downstream impacts of ICD-10 for a typical payer's operations.

Talking Points

- One of the core functions of a payer is to receive, process, and pay claims in an accurate and timely manner and this business area is one of the most heavily impacted by ICD-10.
- Since claims are also used to support other business functions, the impact of ICD-10 is felt throughout a payer organization.
- Many analytic and processing functions are dependent either directly or indirectly on the ICD-10 codes and the aggregation of those codes for specific purposes.

Why Should I Care?
Bad press only pays off in Hollywood

GOVERNMENT HEALTH IT

HOME | TOPICS | ISSUES | WEBINARS | WHITE PAPERS | BLOG | EVENTS | JOBS

RSS | Slideshows | Videos | Newsletters | Advertise

Home » Blogs » Medicaid | Medicare

ORDER A REPRINT OF THIS STORY

6 tweets

An inside look at Maine's MMIS implementation

July 19, 2011 | Brenda Harvey, Executive Director, New England States Consortium Systems Organization (NESCO) and Robin Chacon

Many states struggle to deploy a new Medicaid Management Information System and Maine is no stranger to those issues.

The state's prior MMIS implementation was an initial failure – a worst nightmare realized. The State was unable to process claims for six months and issued \$575 million dollars in interim estimated payments to providers. After a major remediation release failed in 2006, it was evident that the system would never be federally certifiable and a decision was made to replace it. Maine would need to start over. How could this be done differently to ensure the desired outcome?

Suggested Content

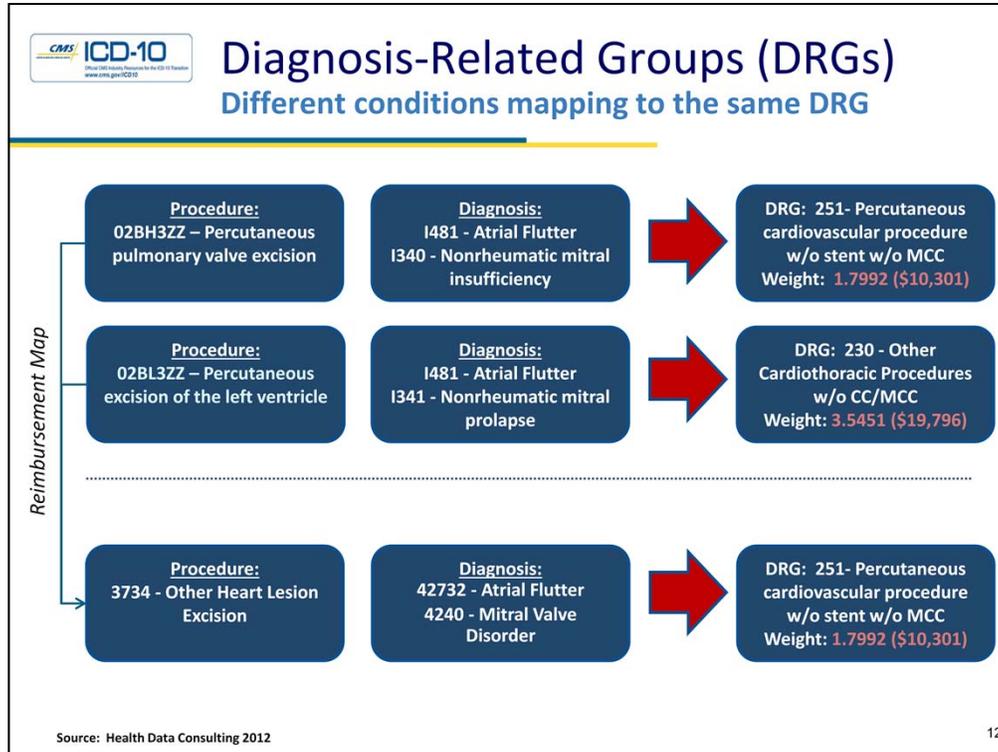
- Health IT may reduce Medicaid costs
- Health IT may reduce Medicaid costs
- Unisys to build Maine Medicaid system
- HHS chooses arena

Purpose of the slide:

Illustrates the potential for a poor public face if transition results in unintended disruption of processing and payment or require a major relook at existing contracted vendors

Talking Points:

- Impacts to operation and system logic could result in catastrophic disruptions



Purpose of the slide

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

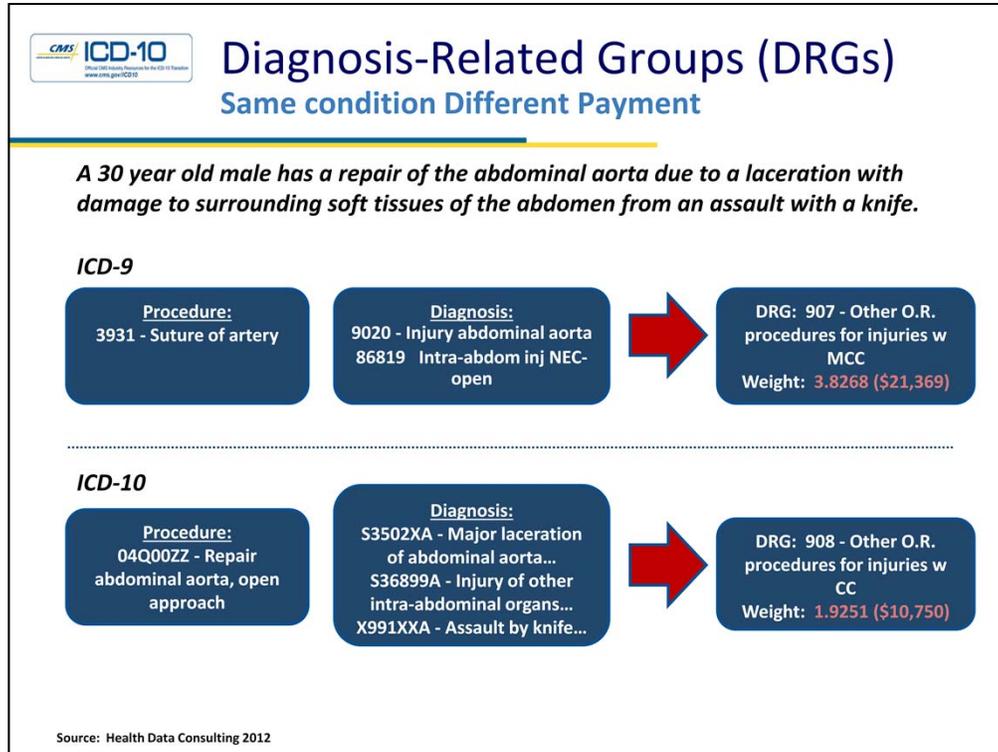
Talking Points

- In this case, the additional specificity in ICD-10 allows for a greater payment for the same services than under ICD-9.
- Though this is an example of where a similar procedures receives more payment in ICD-10, there are also examples where similar procedures receive less payment in ICD-10.
- This particularly shows how two different procedure would map to two different DRGs in ICD-10. If however the payer uses a reimbursement map to get back to a icd-9 codes, those two procedures would map to a single DRG in this case paying less.

Notes

- All dollar amounts assume a base rate of \$5584.12 applied to v28.0 MS-DRG weight. For FY 2011, the national IPPS operating base rate is \$5,164.11. For FY 2011, the national IPPS capital base rate is \$420.01. [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/AcutePaymtSysfctsht.pdf>
- 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
- 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-110.pdf>
- CMS. "Version 28.0 ICD-10 MS-DRGs Update." Accessed 09/13/2011.
<https://www.cms.gov/ICD10/Downloads/V28MsdrgUpdate.pdf>



Purpose of the slide

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

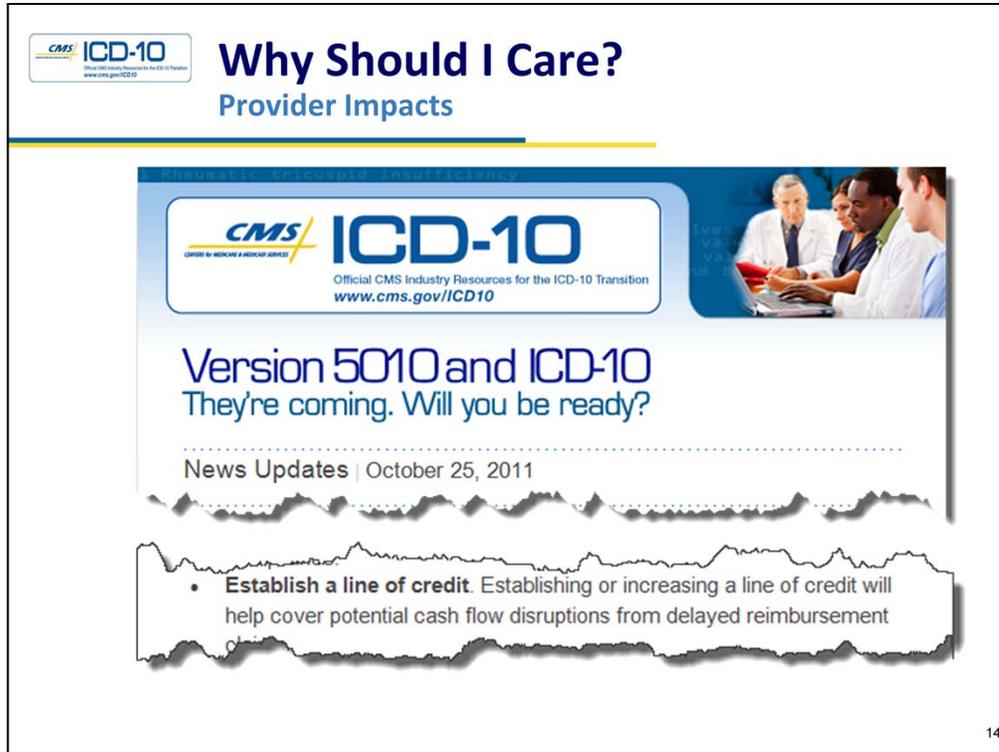
Talking Points

- 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. For FY 2011, the national IPPS operating base rate is \$5,164.11. For FY 2011, the national IPPS capital base rate is \$420.01. [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/AcutePaymtSysfctshst.pdf>
- 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
 - 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>



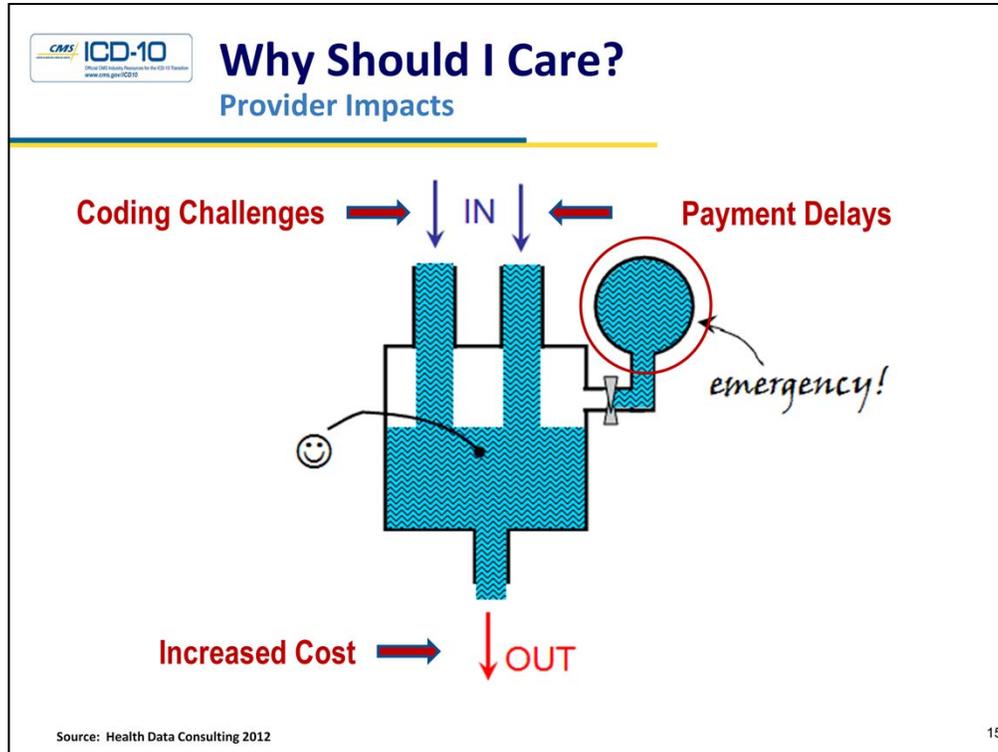
The slide features a header with the CMS ICD-10 logo and the title "Why Should I Care? Provider Impacts". Below this is a graphic with the CMS ICD-10 logo and the text "Official CMS Industry Resources for the ICD-10 Transition www.cms.gov/ICD10". To the right of the logo is a photograph of three healthcare professionals in white coats looking at a laptop. Below the graphic, the text reads "Version 5010 and ICD-10 They're coming. Will you be ready?" followed by "News Updates | October 25, 2011". A torn-paper effect separates this from a list item: "Establish a line of credit. Establishing or increasing a line of credit will help cover potential cash flow disruptions from delayed reimbursement". A small number "14" is in the bottom right corner of the slide frame.

Purpose of the slide:

Illustrates that there may be an impact to provider cash flow

Talking Points:

- Lead into the next slide



Purpose of the slide:

Graphic demonstration of cash flow challenges

Talking Points:

- Coding challenges may decrease productivity and coding accuracy and there for the ability to get correct claims out the door in a timely manner
- Payer challenges may increase denials or delay payments
- Increased costs for ICD-10 implementation may increase out flow
- Reserves will be critical to weather the transition
- Discusses mitigation strategies like interim payments and lines of credit similar to those used during a change-over of MMIS system and/or fiscal agent



Official CMS Website

Why Should I Care?

Penalties

“the amount described in this subparagraph is \$50,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed \$ 1,500,000”.

(45 CFR 160.404, 2 (A_B))

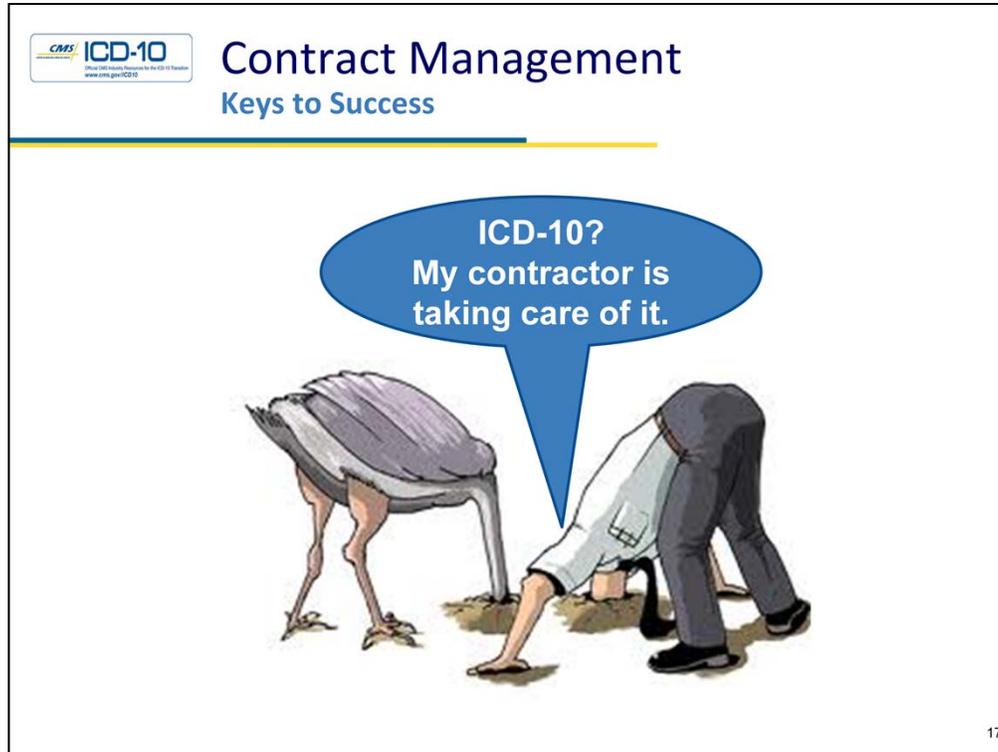
16

Purpose of the slide:

Defines penalties for non-conformance

Talking Points:

- Defined penalties for non-compliance are potentially substantial.
- Must also consider other related penalties around: timely payment, medical loss ratios, meaningful use and CORE compliance requirements under health reform

**Purpose of the slide:**

Demonstrate that contractors are the responsibility of the SMA

Talking Points:

- SMA's are accountable for appropriate management of limited resources in the care of their charges population
- SMA's must monitor and intervene where necessary to assure that contractors are supporting SMA needs around the ICD-10 implementation

Bad Mojo
is not a diagnosis

Clinical Documentation Improvement

It could be a bit better

18

Purpose of the slide:

XXX

Talking Points:

- XXX

CMS ICD-10
Official 2010 Release Document for the ICD-10 Transition
www.cms.gov/ICD10

Coding Challenges

Finding the Code

I25.810	nonautologous biological	I25.810
	with	
I25.739	angina pectoris	I25.739
I25.738	specified type	I25.738
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm	
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	

Source: Health Data Consulting 2012

19

Purpose of the slide:

The next three slides illustrate some of the challenges that coders are facing in the transition

Talking Points:

- This illustrates the difficulty in finding common medical concepts in the standard alphabetical and tabular indexes



CMS ICD-10
Official ICD-10 Category System for the ICD-10 Transition
www.cms.gov/ICD10

Coding Challenges

Same content in many places

Condition	Tabular Category	Number of codes
Hypertension	Hypertensive Disease	14
	<i>Other Categories (14)</i>	115
Pneumonia	Influenza and Pneumonia	38
	<i>Other Categories (18)</i>	42
Genitourinary Disorders	Diseases of the Genitourinary System	587
	<i>Other Categories (14)</i>	535

Source: Health Data Consulting 2012

20

Purpose of the slide:

A second slide to illustrate some of the challenges that coders are facing in the ICD-10 transition

Talking Points:

- This illustrates that because of the combination nature of the codes, codes related to concepts like hypertension, or pneumonia can be found in multiple chapters

 Coding Challenges Changes in Terminology	
ICD-9 Term	ICD-10 Term
Bunionectomy	Resection of Metatarsal
Amputation	Detachment
Arthroscopy, Cystoscopy...	Inspection... Endoscopic Approach
Incision	No Term
Closed Reduction	Reposition (also repair) of (right or left) , (percutaneous, endoscopic, external)
Radical Mastectomy	Resection (right, left or bilateral)
Subtotal Mastectomy	Excision
Tracheotomy	Bypass
Cesarean section	Extraction of Products of Conception
Debridement	Excision, Extraction, Irrigation, Extirpation

Source: Health Data Consulting 2012 21

Purpose of the slide:

A third slide to illustrate some of the challenges that coders are facing in the ICD-10 transition

Talking Points:

- This illustrates some of the significant changes in terminology in the PCS codes
- Coders will need to interpret what is written in the operative report in order to identify the correct codes



CMS ICD-10
Official ICD-10 Release Date: September 8, 2012
www.cms.gov/ICD10

Mapping Challenges

The two sides of Translation

Translation between ICD-9 and ICD-10 involves two different approaches.

- 1. Creating Crosswalks**

- *Definitions for the conversion of one source code to one or more target codes*


- 2. Creating Equivalent Groups**

- *Defining medical concepts that drive policies, rules, and categorizations in ICD-10 that are consistent with the intent of those policies, rules, and categorizations today*



Source: Health Data Consulting 2012 22

Purpose of the slide:

To illustrate the two different types of translation

Talking Points:

- Translation refers to the overall process of moving to an environment that uses the new code set model. It includes both converting data as well as converting rules, algorithms, or categories
- Creating crosswalks to translate from one code such as ICD-10 to another code ICD-9. The crosswalk provides the specification or map for a system to apply the desired conversion
- Creating equivalent groups is the primary way that system policy, rules, and categorization algorithms are updated to support ICD-10



Official ICD-10 Release Date: September 8, 2015
www.cms.gov/ICD10

Mapping Challenges

The Problem with Crosswalks

- Less than 5% of all ICD-10 and ICD-9 codes exactly
- All other codes will either lose information or assume information that may not be true
- Imperfect mapping will affect processing and analytics in a way that impacts revenue, costs, risks, and relationships
- The level of impact is directly related to the quality of translation
- The anticipated quality of translation is currently an unknown
- There is no "default crosswalk" that is universally accepted

Source: Health Data Consulting 2011
23

Purpose of the slide:

Demonstrates some of the issues with crosswalking

Talking Points:

- Based on the GEM mapping files less than 5% of the crosswalks are considered exact or “not approximate”
- Of the crosswalks that are “exact” based on the GEM file, a number of those are not actually exact from a clinical perspective. This will be illustrated subsequently.
- Quality relates to the loss or information or the assumption of information that may not be true. This will be illustrated subsequently.
- Since there is no significant experience with crosswalking and since there are no agreed upon metrics on the quality of the measures, it will be difficult to evaluate crosswalking quality impacts



Mapping Challenges

Crosswalk Quality

 **All concepts and only those concepts represented in in the ICD-9 code are represented exactly in the ICD-10 code**

Example

- ICD-9 code “03642” = Meningococcal Endocarditis
- ICD-10 code “A3951” = Meningococcal Endocarditis

Source: Health Data Consulting 2012

24

Purpose of the slide:

Illustrates a perfect match

Talking Points:

- Quality is measured by the degree to which concepts are lost or assumed.
- This illustrates that each code contains the same concepts “Meningococcal” and “Endocarditis” and that nothing is lost or assumed in translation



Official ICD-10 Release Date: September 8, 2012
www.cms.gov/ICD10

Mapping Challenges

Crosswalk Quality

 **The best match between an ICD-9 and ICD-10 code results in the loss of some concepts in translation and the assumption of some concepts that may or may not be true.**

ICD9 (80084):
OPEN FRACTURE OF VAULT OF SKULL WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE WITH PROLONGED (MORE THAN 24 HOURS) LOSS OF CONSCIOUSNESS AND RETURN TO PRE-EXISTING CONSCIOUS LEVEL

ICD10 (S020xxB):
Fracture of vault of skull, initial encounter for open fracture

<ul style="list-style-type: none"> ▪ Fracture ▪ Open ▪ Vault-Skull ▪ Head and Neck Region 	<p>→</p> <p>→</p> <p>→</p> <p>→</p>	<ul style="list-style-type: none"> ▪ Fracture ▪ Open ▪ Vault-Skull ▪ Head and Neck Region ▪ Initial encounter 	<p>} Assumed Concept</p>
---	-------------------------------------	--	--------------------------

<ul style="list-style-type: none"> ▪ Intracranial ▪ Hemorrhage ▪ Prolonged Loss of consciousness ▪ Return to conscious level 	<p>}</p>	<p>Lost Concepts</p>
--	----------	----------------------

Source: Health Data Consulting 2012

25

Purpose of the slide:

Demonstrate the loss of key concepts and the assumption of one concept that may not be true given only a code value,

Talking Points:

- Uses an ICD-9 code as an example that is more detailed than the mapped ICD-10 code
- In this case, 4 concepts on the left are lost in the translation process and one concept on the right is assumed.



ICD-10
Official ICD-10 Coding System for the US - 10/2013
www.cms.gov/ICD10

Mapping Challenges

Crosswalk Quality



Default mapping can result in assumptions that may not be

ICD-10 Procedure Code	ICD-10 Procedure Term
OX6N0Z0	Detachment at Right Index Finger, Complete, Open Approach
OX6N0Z1	Detachment at Right Index Finger, High, Open Approach
OX6N0Z2	Detachment at Right Index Finger, Mid, Open Approach
OX6N0Z3	Detachment at Right Index Finger, Low, Open Approach
OX6P0Z0	Detachment at Left Index Finger, Complete, Open Approach
OX6P0Z1	Detachment at Left Index Finger, High, Open Approach
OX6P0Z2	Detachment at Left Index Finger, Mid, Open Approach
OX6P0Z3	Detachment at Left Index Finger, Low, Open Approach
OX6Q0Z0	Detachment at Right Middle Finger, Complete, Open Approach
OX6Q0Z1	Detachment at Right Middle Finger, High, Open Approach
OX6Q0Z2	Detachment at Right Middle Finger, Mid, Open Approach
OX6Q0Z3	Detachment at Right Middle Finger, Low, Open Approach
...	

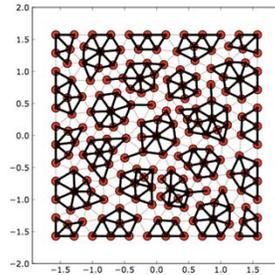
Source: Health Data Consulting 2011
26

Purpose of the slide:

This illustrate a problematic mapping scenario

Talking Points:

- In this case, the map is from an ICD-9 procedure code to a choice of many ICD-10 procedure codes all of which are substantially more detailed than the ICD-9 code
- In this case, the crosswalk must choose between which finger, which level, and which approach even though that information cannot be determined from the ICD-9 code alone.



Equivalent Groups

27

Purpose of the slide:

Transition slide

Talking Points:

- This section discusses the process of redefining code aggregations or groupings for the purpose of redefinition of policies, rules, and categories in an ICD-10 world.
- This process is very different than the process of translating one code to another code or codes.

Code Aggregation Purpose

Aggregation or grouping of codes is used to identify the codes that define some medical concept or intent. These groupings can be applied to:

- *Policies that define conditions under which services are considered:*
 - *Appropriate*
 - *Not appropriate*
 - *Require further manual review*
- *Rules to define:*
 - *Coverage*
 - *Appropriateness*
 - *COB/TPL*
 - *Any other criteria that relies on the use of codes to define the intent of the rule*
- *Analytic Categories that attempt to group claims or other data based on types of services or conditions as defined by set of codes.*

Purpose of the slide:

This slide illustrates the purpose of code aggregation and redefining those aggregations in an ICD-10 world

Talking Points:

- Policies, rules, and categories are all created with some intent related to a service or condition. This intent is generally translated into an aggregation or grouping of codes that identifies those claims that apply to policies, conditions, and services, that are incorporated into rules and algorithms and condition or procedures that should be included in any category of analysis
- It is important to emphasize that these policies, rules, and categories are not about codes, but are about the services and conditions that are represented by these codes. The codes that represent these conditions and procedures are very different in ICD-10 as compared to ICD-9.

Industrial Injury COB Rule Example

Median Nerve Injury

Aggregation of codes that represent "Open Fractures of the Femur".

Native ICD-9 definition = [15] Codes

- GEM ICD-9 to ICD-10 = [44] ICD-10 codes (ICD-9 is the source code)
- GEM ICD-10 to ICD-9 = [270] ICD-10 codes (ICD-9 is the target code)

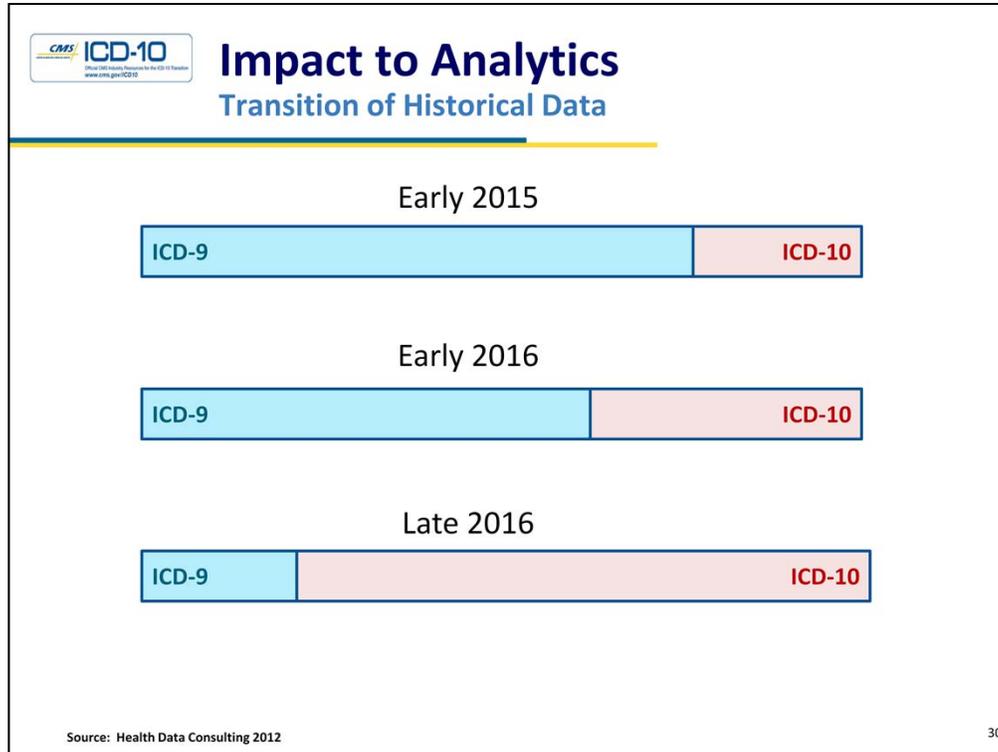
Native ICD-10 definition = [1530] Codes

Purpose of the slide:

Similar example to the prior slide but a specific example related to a common rule

Talking Points:

- In this example, the rule is attempting to identify claims where some median nerve condition might suggest a third party liability or industrially related injury where Medicaid may be secondary
- A native definition of the group of ICD-9 codes identifies 3 codes that meet the intent of this rule
- A mapping of these defined ICD-9 codes to ICD-10 using forward and backward mapping with GEM identifies a maximum of 15 unique ICD-10 codes
- Direct research of the ICD-10 codes (Native Redefinition) reveals 33 codes that meet the intent of the rule
- In this case, the GEM backward and forward maps left out about half of the candidate codes.
- Dollar impact \$ 20,696,710.58 for 3 years of blues data for 1 million lives



Purpose of the slide:

This slide illustrate the challenge with mixed data in historical data sets and how that mix will change over time

Talking Points:

- Discuss the fact that in order to look at trends, comparisons, and other uses of historical data, there will need to be a process of normalization of the data in data warehouses and date marts



Impacts to coverage

Special Populations

Coverage for Down's Syndrome

ICD-9 Code	Description
7580	Down's syndrome

ICD-10 Code	Description
Q909	Down syndrome, unspecified
Q901	Trisomy 21, mosaicism (mitotic nondisjunction)
Q922	Partial trisomy
Q928	Other specified trisomies and partial trisomies of autosomes
Q929	Trisomy and partial trisomy of autosomes, unspecified
Q00	Trisomy 21, nonmosaic (meiotic nondisjunction)
Q902	Trisomy 21, translocation
Q920	Whole chromosome trisomy, nonmosaic (meiotic nondisjunction)
Q921	Whole chromosome trisomy, mosaicism (mitotic nondisjunction)



Official ICD-10 Release Document for the ICD-10 Transition
www.cms.gov/ICD10

Impacts to Analytics

Quality Measures – *Acute Myocardial Infarction*

- **Definition of acute myocardial infarction (MI) has changed**
 - ICD-9 – Eight weeks from initial onset
 - ICD-10 – Four weeks from initial onset
- **Subsequent vs. Initial episode of care**
 - ICD-9 – Fifth character defines initial vs. subsequent episode of care
 - ICD-10 – No ability to distinguish initial vs. subsequent episode of care
- **Subsequent (MI)**
 - ICD-9 – No ability to relate a subsequent MI to an initial MI
 - ICD-10 – Separate category to define a subsequent MI occurring within 4 weeks of an initial MI

32

Purpose of the slide:

Illustrate how Quality measures may be impacted based on definitional changes in the codes

Talking Points:

- Change in the definition of acute myocardial infarction will impact the denominator value of several quality measures
- The loss of the initial vs subsequent encounter concept in ICD-10 will change the logic for measures such as use of beta-blockers after an acute MI
- The concept of subsequent MI is new to ICD-10 and has not been used in historical measures



Leveraging ICD-10

Improved Information – Improved Business

Purpose of the slide:

Transition slide

Talking Points:

- The following two slides speak to leveraging the advantages of ICD-10



Leveraging ICD-10

SMAs' Business Advantages

ICD-10 advantages

- Detailed medical concepts
- Enhanced categorization models
- Granularity in severity and risk definitions
- Greater forward flexibility
- Enhanced clinical information integration

ICD-10 advantages lead to SMA health plan and business advantages

- Established Compliance Model
- Improved Contracting
- Enhanced Network Management
- Enhanced Fraud, Waste, Abuse Prevention and Detection
- Enhanced ability to predict risk population
- Improved Claims Payment Accuracy and Efficiency
- Opportunity to Improve Coding Practices among Providers
- More Accurate Understanding of Population Health
- Opportunity to Improve Precision and Accuracy of Payment Policies
- Opportunity to Improve Accuracy of Quality Measures
- Opportunity to Improve Care and Disease Management

34

Purpose of Slide:

Discuss the significant improvement opportunities ICD-10 implementation provides to the healthcare industry specifically around quality and detail embedded within the code structure

Talking Points:

Advantages are not helpful unless the SMA is able to put them to use. These are some example business advantages of ICD-10.

ICD-10 codes provide a number of information advantages:

Detailed medical concepts

ICD-10-CM and ICD-10-PCS offer more detail in medical concepts related to the ICD codes than the ICD-9-CM codes. The additional detail captures **patient health conditions** as well as the **inpatient procedures** with the intent to maintain or improve the specified health condition.

Enhanced Categorization models

The level of detail supported by ICD-10 codes allows for meaningful categorization for analysis of data to support actionable business intelligence. Comparisons represent comparable categories of service and conditions unlike with ICD-9-CM.

Distinguish risk factors for health conditions using increased granularity in severity and risk definitions:

ICD-9-CM diagnosis codes for fractures involving the growth plate describe at a single level. ICD-10-CM codes describe these fractures at four levels. For example, a "Salter Harris I" level requires little treatment, but a "Salter Harris IV" fracture requires immediate complex and precise surgery and the risk of permanent growth deformity is extremely high. ICD-10-CM captures the differences between these two procedures.

Enhanced flexibility to add codes in the future

The design of ICD-10 codes including more characters, alphanumeric values, and placeholders provides the ability to add codes in the future without disruption of the existing code structure.

Enhanced ability to integrate clinical information

ICD-10 codes support the ability to define risk and severity factors, and addition of key clinical information, which better describes the patient health state. The following are some of the parameters of health conditions that are included in ICD-10 codes:

- Co-morbidities
- Complications
- Severity
- Manifestations
- Causation
- Etiologic agents
- Laterality
- Precise anatomical locations
- Disease phases
- Morphology
- Fracture patterns

ICD-10 codes provide a number of health plan and payer advantages:

Compliance

As a regional leader in the healthcare industry and an arm of government-supported healthcare, SMAs should provide leadership in compliance with mandated standards. Providers will be looking at government leadership in their assessment of their own transition.

Better contracting

The precision of ICD-10 codes and the ability to stratify severity and risk provides more appropriate contracting opportunities for providers with respect to the burden of illness providers manage. Over time, SMAs will be able to analyze contracting models and apply them with greater effectiveness.

Improved Claims Payment Accuracy and Efficiency

Similar to contracting, ICD-10 provides the opportunity for greater recognition of the severity of conditions and the complexity of services. Using this information, the SMA can develop more appropriate payment models that distribute payment based on the greatest patient need and the most complex level of services.

Enhanced ability to predict risk population

The SMA often predict population risk by assessing the pattern of health conditions that exist in a population. The added ability in ICD-10 to identify the parameter of conditions that results in a significantly different burden of illness will greatly improve the ability to predict risk and resource utilization.

Better fraud, waste, abuse prevention and detection

The detection of fraud, waste, and abuse is an ongoing challenge across all healthcare industries in part because of the limited data and imprecise nature of the data that is available. The increased precision and content of ICD-10 can support sophisticated detection and analysis of potential fraud, waste, or abuse cases. To realize this benefit, SMAs need to create system rules that leverage this additional content.

Enhanced network management

The SMAs can use ICD-10 content to obtain precise information about network performance and stratification of illness within locations served by providers. The SMAs can use this information to look at network adequacy, network provider quality and efficiency, and the nature of the patient conditions served by regional providers.

More accurate understanding of population health

The additional detail and precision supplied by ICD-10 codes provides the ability to assess the patterns of conditions that exist within populations. The SMAs can define shifts in patterns of illness in a timely fashion to support patient-health improvement measures to mitigate health risk associated with these changing patterns of illness.

An opportunity to reach out to providers to improve coding practices

Providers must use ICD-10 codes appropriately in order to record patient health conditions or the nature of institutional procedures accurately. The SMAs will not realize the advantages offered by ICD-10 codes unless providers use ICD-10 codes appropriately. The SMAs have an opportunity to work with providers directly or in cooperation with local initiatives and associations to provide education, training, and other activities to assure that all trading partners benefit from the advantages offered by ICD-10 codes.



Leveraging ICD-10
Key indicators of risk and severity

- Co-morbidities
- Manifestations
- Etiology/causation
- Complications
- Detailed anatomical location
- Sequelae
- Degree of functional impairment
- Phase/stage
- Lymph node involvement
- Procedure or implant related

35

Purpose of the slide:

List some of the key concepts supported in ICD-10 that have substantial impacts on the nature of risk and severity of the patient condition

Talking Points:

- Use a patient story such as grow plate injuries, open fracture or similar conditions to illustrate these concepts



Executive Support

Leading the organization through a successful transition

- **Resources**
 - People, Time, Training and Tools
- **Empowerment**
 - Providing the authority to succeed
- **Oversight**
 - What needs to get done? Is it happening?
- **Coordination**
 - Breaking down silos. Synchronizing efforts
- **Contingencies**
 - What if?
- **Vision**
 - The road map for leveraging ICD-10

36

Purpose of the slide:

This slide is to illustrate the requirement for executive support

Talking Points:

- Discuss the enterprise nature of ICD-10 and the need to empower accountable people in the organization and give them the resources to get the job done
- Focus on the need to break down barrier across the organization to improve efficiency and get a unified direction with a single point of truth.



Questions

