

ICD-10 and Medicaid

- ▲ Overview of ICD-10 History
- ▲ ICD-10-CM Structure and Content – Diagnosis Codes
- ▲ ICD-10-PCS Structure and Content- Procedure Codes
- ▲ The Impact of ICD-10 on Medicaid Programs
- ▲ Planning for ICD-10
- ▲ Identify resources for further information
- ▲ Closing and Review



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- ▲ ICD-10 is the biggest change in standard coding systems in over 20 years
- ▲ Implementing ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code
- ▲ Major changes of ICD-10 include
 - Codes use alphanumeric characters
 - Combination of diagnosis/symptom codes
 - Expanded to a potential seven digits (currently 5 maximum)
 - Codes are far more specific, for example
 - Obstetric codes identify trimester
 - Expanded injury codes set, with a different grouping approach (by site rather than by type of injury)
 - Expanded sets of codes for postoperative complications

- ▲ The industrialized world has used a common system for coding diagnoses since the late 19th century.
- ▲ The diagnosis coding system currently in use in the United States is ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification). ICD-9 is a classification system of diseases, injuries and medical conditions that was developed by the World Health Organization; ICD-9-CM is a U.S. variant maintained by the National Committee for Health and Vital Statistics. NCHVS revises the codes each October 1. These diagnosis codes are almost always required on health care claims.

- ▲ ICD-10 is the tenth revision of the International Classification of Diseases. It was developed by the World Health Organization and has been in use in much of the industrialized world since 1995.
- ▲ The proposed diagnosis coding system for the United States is ICD-10-CM, a variant of ICD-10. ICD-10-CM was developed for use in the United States by NCHVS. Because ICD-10 does not include a procedural coding system, ICD-10-PCS has been developed by CMS for coding inpatient hospital procedures.

- ▲ H.R. 4157: Contains requirement to implement ICD-10. Passed the U.S. House of Representatives, and had a second reading 9/5/06
- ▲ S. 1418 is in conference committee, to negotiate differences with H.R. 4157 (Contains no reference to ICD-10)
- ▲ CMS will be responsible for promulgating the federal regulation regarding ICD-10, as a modification of the HIPAA Transactions and Code Set rule.
- ▲ The earliest implementation date would be January 2009, though it appears likely to be later than that.

ICD-10 is publicly supported by AMA, AHA, AHIMA, HHS among others

Statement by Mark McClellan, CMS, July 2006

We're also looking to support movement to ICD-10 codes as soon as possible. ICD-9 is 27 years old, nearly out of space and has limited ability to accommodate new procedures and diagnoses. It lacks the precision needed for a number of current needs, such as the kinds of performance-based payments we need, more accurate billing, and public health monitoring for unusual patterns of complications and adverse events. The ICD-10 code set will address these shortcomings. We will seek public comment on how we can move to ICD-10 quickly and effectively

- ▲ In a November, 2003 letter to the Secretary of Health and Human Services, the American Hospital Association and the Federation of American Hospitals wrote,

“Adoption of ICD-10-CM and ICD-10-PCS will better position health care providers to improve the quality of health care data, which is essential to improving the quality of patient care.”



- ICD-10 is copyrighted by the World Health Organization
 - Diagnosis coding system
 - Used for mortality reporting in the U.S. since 1999
 - Used by 99 countries, including virtually all of the industrialized nations, since 1995
 - Published in 37 languages
 - U.S. variant (ICD-10-CM) developed by the National Committee for Vital and Health Statistics (NCVHS)
- ICD-10-PCS has been developed by CMS
 - Inpatient procedure codes
 - Replaces ICD-9 procedure codes (Volume 3)
 - Strictly for use in the United States

ICD-9 vs ICD-10, by the numbers



	ICD-9 U.S. Version	ICD-10 U.S. Version
Diagnosis Codes	ICD-9-CM Volumes 1 and 2	ICD-10-CM
Number of Characters	3-5 Alphanumeric	5-7 Alphanumeric
Number of Codes	15,000	120,000
Procedure Codes	ICD-9-CM Volume 3	ICD-10-PCS
Number of Characters	3-4 Numeric	7 Alphanumeric
Number of Codes	4,000	200,000- 450,000

- ▲ Diagnosis codes impact all professional and institutional claims
- ▲ This is a complete replacement of the existing system- there is a potential of 120,000 distinct diagnosis codes, compared to the existing 15,000 codes
- ▲ Codes are 7 character alpha-numeric
- ▲ ICD-10-CM contains three levels for coding diagnoses: categories, subcategories and codes.
- ▲ Only codes are appropriate for reporting purposes. To help identify whether a category or subcategory qualifies as a code, all codes are presented in bold faced type in ICD-10-CM
- ▲ Each character for all categories, subcategories and codes may be either a letter or a number
- ▲ All letters are used, except for I and O, to avoid potential for confusing those characters with lower case L or the numbers one or zero

- ▲ The system was designed to meet four primary objectives: completeness, expandability, being multiaxial and using standardized terminology.
 - Completeness: each substantially different procedure will have a unique code.
 - Expandability: expands to accommodate new medical procedures.
 - Multiaxial: Each of the seven characters in a procedure code has a standard meaning within and across procedure sections. Each character within the 7 digit code has a meaning and can be viewed separately. This allows for greater precision and accuracy in assigning procedure codes.
 - Standard terminology: Coding precision is enhanced with a standard meaning for each character.
- ▲ The procedure codes deliver only procedural information, and contain no diagnostic information.
- ▲ The NOS (Not Otherwise Specified) option has been eliminated. All possible procedures can be defined and coded within ICD-10-PCS.

- ▲ All inpatient hospital claims will require the new procedure codes
- ▲ The new procedure codes are 7 digits, and each digit holds intelligence
 - 1 Refers to one of the chapters of ICD-10
 - 2-7 Mean the same thing within each section, but may have different meanings across sections.
 - The third character always specifies the general type of procedure being performed. The other characters provide other specific information, such as device used, approach, etc.

Sample ICD-10-PCS Code



Breaking down a seven digit procedure code		
02100Z4: Bypass, one coronary artery to right internal mammary artery, open		
Character	Function	Example
1	Refers to ICD section. There are 16 sections in ICD-10	0: Medical and Surgical
2	Refers to the body system where the procedure is performed	2: Heart and great vessels
3	Refers to the root operation, or underlying objective of the procedure.	1: bypass
4	Refers to body part	0: one coronary artery
5	Refers to approach	0: open
6	Refers to device used	Z: none
7	Refers to qualifier	4: right internal mammary artery

The first character of the procedure indicates section of ICD.

The possible sections are:

- 0 Medical and Surgical
- 1 Obstetrics
- 2 Placement
- 3 Administration
- 4 Measurement and Monitoring
- 5 Extracorporeal Assistance and Performance
- 6 Extracorporeal Therapies
- 7 Osteopathic
- 8 Other Procedures
- 9 Chiropractic
- B Imaging
- C Nuclear Medicine
- D Radiation Oncology
- F Physical Rehabilitation and Diagnostic Audiology
- G Mental Health
- H Substance Abuse Treatment

▲ Questions/Break

What Does All This Mean for Medicaid?



▲ MMIS

- Reference file structure and content
- Claims processing- electronic transactions, keyed claims
- DRG grouping, OCE edits, CCI edits
- Reporting
- Internal business rules that hinge on diagnosis codes
- Data extracts, layout and content
- Data imports, layout and content

▲ Other systems (integrated with MMIS or not)

- Decision support
- SURS
- Financial reporting/ federal draw calculation
- Prior Authorization contractors/systems
- Utilization Review contractors/systems

Medicaid programs frequently implement health policy by flagging or restricting diagnosis codes, or by restricting procedure codes to certain diagnosis codes. Examples include

- Denying payment for emergency services for certain diagnoses not considered emergent.
- Requiring prior authorization for certain diagnosis codes
- Using diagnosis codes to define whether a service qualifies for improved federal match, such as for family planning
- Using diagnosis codes to determine whether a service is covered, such as a mental health service

- ▲ This is a complete re-working of DRG grouping algorithms
- ▲ CMS has indicated that they are likely to map codes to their “original” DRG during a transition phase. A new DRG grouper would be developed for subsequent years. It will be important to watch for this issue in the proposed rules
- ▲ It will not be possible to crosswalk the new diagnosis codes and procedure codes to an older version of the grouper
- ▲ Consider updating to a current grouper in the near future, in order to utilize CMS mapping of the new codes

- ▲ Assess the need to retain historical coding information
 - Research data
 - Case mix analysis
 - Trending of clinical data
 - DRG related financial information
- ▲ Consider vendor's ability to comply with ICD-10 when procuring or renewing contracts for processes or systems where diagnosis information will be exchanged



- ▲ Establish an ICD-10 steering committee
 - Build organizational awareness and commitment
 - Identify key stakeholders
- ▲ Evaluate interfaces where codes are exchanged
- ▲ Assess your areas of risk
 - Identify all systems that utilize or hold diagnosis codes
 - Identify all processes/policies that utilize diagnosis codes
 - Identify all contractors that rely on diagnosis codes
 - Determine and encourage provider readiness
- ▲ Prioritize remediation efforts
 - Claims processing
 - Reporting (federal match issues)
 - Provider readiness
 - Ancillary processes

▲ Assess your system

- Where are diagnosis codes used?
- How are they used?
- Where is remediation required?
- How much/what kind of historical information needs to be retained?

▲ Assess Medicaid policy

- Which Medicaid policies are driven by diagnosis codes?
- Where are those policies implemented in your system?
- What decisions need to be made in implementing new diagnosis codes?
- Who will make those decisions?

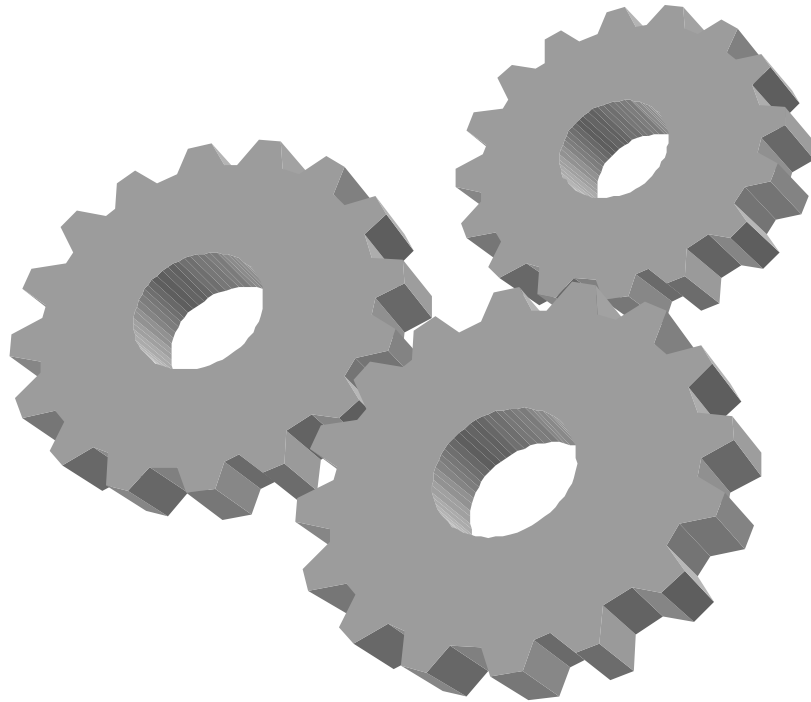


TEST

- ▲ Test claims processing
 - Receiving/processing/paying
- ▲ Test reporting
- ▲ Test auxiliary systems/processes
- ▲ Test data exchanges w/ business partners

TRAIN

- ▲ Train state staff
- ▲ Train fiscal agent staff
- ▲ Remind providers of training options



Critical Success Factors

- ▲ State management commitment
- ▲ Thorough assessment
- ▲ Adequate planning
- ▲ Trained staff
- ▲ Thorough testing
- ▲ Communication
- ▲ Timely decision making

- ▲ The following websites have additional information on ICD-10:
 - www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp
 - www.ahima.org/icd10/faq.asp
 - www.3Mhis.com
 - www.icd-10-ready.com (3M site)

- ▲ Questions, discussion and review

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