



America's Health
Insurance Plans

**IMPACT OF ICD-10 CODE SET ADOPTION
ON HEALTH INSURANCE PLANS**

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1.0 Executive Summary

1.1 Background

Currently the ICD-9-CM is used for diagnosis coding in most inpatient and outpatient settings. These codes are contained in Volumes 1 and 2 of ICD-9-CM. Volume 3 of ICD-9-CM includes procedure codes used in inpatient institutional settings (e.g. hospitals). These codes have been in use since the late 1970s.

The use of ICD-10 codes for medical diagnosis and procedure coding has been debated for a number of years. The primary reasons given for changing to the new coding system are concerns that the current ICD-9 Codes may be inadequate and do not provide sufficiently detailed information needed for health research and statistical analysis.

On the other hand, the migration to ICD-10 diagnosis and procedure codes would result in a substantial increase in the number of fields used for the coding process and a significant change to a system by using both numbers and letters as part of the Codes. For example, the current diagnosis codes are a numeric system (with some supplementary letter codes) using a minimum of 3 digits and a maximum of 5 digits. In contrast, ICD-10 diagnosis codes combine letters and numbers and use between 3 and 6 digits. Likewise, the current ICD-9 procedure codes are numeric with a minimum of 3 and a maximum of 4 digits, while the ICD-10 procedure codes are alphanumeric with 7 required digits.

The newer codes were intended to be more complete, expandable, and provide greater information about the services represented by the code. Achieving these goals does not come without some challenges. To identify what these challenges are, Ken Fody of IBM worked with staff from America's Health Insurance Plans (AHIP) and a task force of representatives from AHIP member health plans who represented a cross section of AHIP's membership.

1.2 Discussion

Adoption of the ICD-10 Code Sets has become a question of when, not if, yet there is still trepidation within the health care industry about adoption of these Code Sets. This reluctance stems from concern on the part of some within the health care industry, particularly payors, that there is not an appreciation of how challenging and costly this project will be and that the key activities, such as adoption of new HIPAA Transactions will be bypassed, and the time frame for adoption shortened. The purpose of this report is to describe the impact of changing to ICD-10 Code Sets on health insurance plans, including a discussion of the impact, timing, and cost.

Because of the significance of this effort, it is recommended that the period for implementing the ICD-10 Code Sets be three years. The three years would be used by health plans to assess their needs, prepare detailed project plans, for business areas to define their requirements and identify how their business processes will change. The work itself, designing and building the changes to systems and processes, will take some time to complete and then there will need to be adequate time for testing, training, and re-contracting between payor and providers, covered entities and business associates, and between trading partners.

These activities should be preceded by a period of 6 to 18 months for health care organizations to plan and budget resources for the work – both human resources and financial. Money is not just laying around waiting to be spent on this project. Organizations need time to allocate funds through their normal budgeting processes and re-assign staff. Larger organizations have IT budgets and activities that are planned out as far as 18 months in advance. This planning period could coincide with the time period required to implement the ANSI X12 v.5010 Transactions.

Prior to the clock starting on the implementation of the ICD-10 Code Sets, the industry should be required to migrate to the ANSI X12 v. 5010 Transactions. The current transaction sets are not adequate for reporting the ICD-10 Code Sets. If the goal is to achieve thorough use and adoption of the ICD-10 Code Sets, then having appropriate transactions in place is a pre-requisite. It should also be recognized that adopting these updated transactions is not the same as updating software on a computer. Until the adoption of updates to transactions becomes a regular and routine process, the previous experience of the industry in adopting the original HIPAA transactions is a better indicator of the trials and tribulations what will occur when moving to the next generation of the transactions. Therefore a 24 month period is recommended for the adoption of the ANSI X12 v. 5010 Transactions.

As described herein, every area within a payor organization will be affected by the adoption of the ICD-10 Codes. This is not simply a process of expanding field sizes and reprogramming logic. Business areas will be required to re-evaluate their existing policies, procedures, and processes. There will be extensive re-writing of reports. Provider contracting and communications with providers and other constituencies will be a significant effort. When all of that effort and the IT work is done, everything will have to be tested both internally and with trading partners to make sure it all works as intended.

That said, adopting the updated transactions should not preclude adopting a mandate for using the ICD-10 Codes. On the contrary, it is recommended that rules requiring both the ANSI X12 v. 5010 Transactions and ICD-10 Code Sets be promulgated at the same time. The rules should state that the three year period for implementing the ICD-10 Codes shall begin when the 2 year period for adopting the 5010 Transactions is completed. Mandating the ICD-10 Codes this way will trigger health plans conducting the process of planning and budgeting for these changes.

In this way, the health care industry will have a clear road map of the activities ahead and can better plan for these. For example, health care entities can more properly budget their resources given the longer time frame. Some entities may begin work on the ICD-10 Codes earlier in order to achieve greater adoption and use of the codes. Some entities may find that work related to the implementation of the ICD-10 Code Sets corresponds with activities required to implement the 5010 Transactions and that it is more efficient to combine certain aspects of these projects. It also means that costs can be spread out over a longer period of time, which reduces the size of possible rate increases required to fund this work.

This is important because the financial cost to payors for implementing the ICD-10 Code Sets will be significant. As indicated in Section 4.0, the estimates previously circulated in the studies referred to as the Rand Report¹ and the Nolan Report² were evaluated in light of the impact to payor organizations described in Section 2.0. It was found that the cost estimates in the Nolan Report, \$432 million to \$913 million for payors, were much closer to accurately capturing the work effort involved in implementing the ICD-10 Code Sets than was the Rand Report. The Nolan Report specifically mentioned levels of activity that the Rand Report overlooked. Additionally, there are activities that neither the Rand nor the Nolan report mentioned. Also, there is the possibility that some vendors may choose not to bear the costs of modifying or upgrading their systems and instead impose special surcharges on customers to offset these costs. This was an experience seen during the HIPAA implementation period.

If the ICD-10 Code Sets are adopted, the goal should be to see that all health care entities – payors, providers, vendors, and any other entity involved or affected – adopt and utilize the ICD-10 Code Sets to the fullest extent possible given their individual business model. This is consistent with the public policy goals behind adoption of the ICD-10 Codes; it is also consistent with the direction the industry is currently taking towards developing a robust national health infrastructure network.

¹ *The Costs and Benefits of Moving to the ICD-10 Code Sets* prepared for the Department of Health and Human Services by Martin Libicki and Irene Brahmakulam of the Rand Corporation (hereafter referred to as the "Rand Report")

² *Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS – Challenges, Estimated Costs and Potential Benefits* prepared for Blue Cross and Blue Shield Association by Robert E. Nolan Company, October 2003 (hereafter referred to as the "Nolan Report")

The view that adequate time should be allowed to permit greater adoption, rather than providing less time and encouraging short-cuts, is also consistent with the current activities within the payor market. Payors are actively working to obtain more information and better utilize the information they do have available for disease management, case management, and pay for performance programs, and also to assist members with consumer directed health plans with tools such as personal health records.

Payors are also being asked by large groups and governmental programs, such as Medicare and Medicaid, to provide more information about performance and medical care.

Payors would welcome any value that comes from the ICD-10 Code Sets if the process of adopting these recognizes the concerns of payors about the level of effort and cost involved. Fortunately, the two points are not mutually exclusive. Providing an approach to implementation such as the one outlined herein will enhance the prospects that the ICD-10 Code Sets will be correctly implemented and adopted.

2.0 Effect of Adopting ICD-10 on Payor Operations

2.1 Claims

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. This logic represents business rules that are embedded into the system. The purpose of these rules is to automate processing for the purpose of speeding claim adjudication while reducing administrative costs.

The following is a discussion of specific business processes and systems within a claims unit that could be affected by adoption of the ICD-10 Codes.

Keep in mind that for many payors, there is not a single "claims" department or "claim" system. Some payors have different systems for different lines of business, e.g. HMO versus fee for service products like PPO and indemnity, or different systems for ancillary services like dental. Similarly, there can be different areas within the company with their own set of claim rules that vary by product, state, or market segment (e.g. individual versus ERISA self-funded accounts). So the activities described below may have to be repeated multiple times within a payor organization.

2.1.1 Need correct codes on claims

Incoming claims must have the correct codes on them to be processed. This will mean that after a particular date in time, only ICD-10 codes will be permitted. If these codes are not on the claims then the claim will be rejected.

Some payors have staff assigned to correcting claim errors rather than rejecting claims. The change to the ICD-10 codes will create additional burdens for this process while both sides become accustomed to the new numbers. The burden will be an increase in the number of claims to repair and the need to retrain staff on the new code sets.

For EDI claims repairing invalid codes are not permitted. A covered entity cannot accept a non-compliant claim and a claim received with an invalid code is non-compliant.

All of this will result in a period of time when many more claims are rejected during the transition period. These codes will be resubmitted and re-processed increasing the workload on payors. This costs money for either adding staff or paying overtime.

2.1.2 Claim edits need to be updated to reflect new codes

Claim systems process claims using edits tied to specific codes. These edits are an example of the business rule logic built into claim systems to speed processing and reduce costs. Adoption of the ICD codes will require Payors to re-evaluate all of these rules to determine how to re-code all of the current edits that are tied to ICD-9 codes.

The process will involve various business areas being involved in reviewing the business rules to determine what these are, how they are coded into the edits within the claim system, how these rely on the ICD-9 codes and what the impact will be of migrating to the ICD-10 codes. The number of edits involved means this will be a time consuming process, as will the fact that Payors should spend some time re-evaluating each of the edits and not just map them to new codes.

Finally, the edits will have to be modified. Some of these edits involve reconfiguring the application using built in tools or options. However, in some legacy systems, modifying the edits means re-programming the system as the edit could be "hard coded."

2.1.3 Codes used to determine reimbursement rate – system driven

As stated in above, ICD codes are used to determine reimbursement levels. Much of this is done in the provider reimbursement tables that are typically controlled outside the claims area, and that is discussed later in this document. However, there are reimbursements driven by codes within the system. These will have to be identified and modified to reflect the new codes.

As with the edits, these will have to be evaluated by the business areas and decisions made on how they will function with ICD-10 codes. Then the claims application will have to be modified

2.1.4 Codes used to determine whether the claim is a covered service

To evaluate whether a claim is a covered service, codes are used:

- In benefit tables to determine whether a service is covered under a particular policy,
- In conjunction with the provider taxonomy to determine whether a provider can render the service the code describes,
- 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)

Updating these rules will be more straightforward in that there will not need to be the same intense business analysis. However, these still need to be modified within the system either by reconfiguring the system using tools and options provided by the vendor or possibly in having to re-program legacy applications where the rules are hard coded into memory.

2.1.5 Need to retrain staff on new Codes

Staff will need to be retrained on reading and understanding the ICD-10 codes. A training program will have to be designed, tested, and implemented. In addition to the cost of creating the training program, the time spent by staff in training is time away from work. This will result in payment of overtime and/or time away from work during regular hours.

Staff who had become familiar with the ICD-9 codes will have to start over with the ICD-10. This will be a loss of "institutional memory" (e.g. examiners who knew codes by heart will have to start over) that will slow payor processes in the future.

2.1.6 Increased error rates as providers put wrong Codes on claims

This is different from claims submitted with old codes. This represents the impact of providers submitting claims with incorrect codes. This will result in 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 causes a claim that was previously adjudicated to be re-opened and re-processed.

The impact during the process of implementing the ICD-10 codes is that payors will identify the possible effects of this and create work-arounds to address them. These work-arounds will likely be creating new reports to identify problems and/or redundant processes to find and correct these errors.

To avoid this, payors will have to develop tools and strategies to assist providers with coding properly to reduce the possibility of increased errors. This will be particularly important as it regards smaller providers who may not have access to the type of staff training and automated tools that larger providers might use to prepare.

2.1.7 Claim history will have to be mapped from old codes to new for data reporting purposes

Member claim history is used for a variety of purposes that range from many different types of reports to benefit accumulators. To compare historical claim data using ICD-9 codes with claims using ICD-10 codes, Payors will have to identify a way of mapping, or matching the old codes with the new so that there is some correlation between the old and new claims.

This will be extremely challenging because the typical ICD-9 code maps to many potential ICD-10 codes. Finding the right match will require arduous trial and error, it cannot be easily automated.

Therefore setting up the data crosswalks will require a business analysis of all the different activities affected and development of a solution for each (granted one solution can fit many problems). This solution will have to then be designed and built. This alternative means of matching data will remain in effect for at least a few years as the various business processes for which the older claims history could be needed play out.

2.1.8 Applications used to look up claims may have to be modified

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.

Also, many of these applications have prompts or other supporting tools to help the user understand what they are reading. To the extent these convert ICD codes into plain English, these features will also have to be updated.

2.1.9 Reimbursement rates for providers not in-network (e.g. non-par providers) will have to be adjusted

Claim systems utilize reimbursement rates not just for participating or contracted providers, but also for non-participating providers. For example, it is not uncommon to see reimbursement to non-par providers at some percentage of Medicare's fee schedule for particular diagnosis codes. These reimbursement tables will need to be modified to reflect the new codes.

To the extent that the Payor reimburses using something other than a table driven by a public fee schedule, like the Medicare rates, the Payor will have to modify those rates by code as well. Similarly, Reasonable and Customary fee schedules will be impacted, because they are based on experience.

When the industry converts to the ICD-10 codes, there will be no direct experience on which to base these rates. Using experience from ICD-9 codes will not account for the richer data available in the ICD-10 codes that distinguish severity, for example.

Invariably, decisions made in re-pricing claims that are based on ICD-10 Codes will give rise to debate and dissension between payors and providers. Specifically, Reasonable and Customary fee schedules are based on two factors – what the customary charge is for a service in a given geographic area, and what is a reasonable charge for that code. Given the variety of new codes for every one old code, providers may set prices higher than what payors feel are reasonable given the nature of the service rendered. Similarly, without historical experience as to how providers price a code, payors will be unable to determine what is “customary” so they will make their own determinations. It is inevitable that some providers will think that the payor’s have set pricing for some codes too low. Members will be caught in the middle of this because providers often bill the member for the difference between their charges and what the insurer pays.

2.1.10 EOBs will have to be rewritten to use new codes and possibly to explain their meaning

EOBs are Explanations of Benefits and refer to paper documentation this is sent to members explaining why or how a claim was adjudicated. Payors generally spend a fair amount of time developing EOBs. At a minimum the applications that generate EOBs will have to be re-done to accommodate the different size and format of the ICD-10 codes. Also, to the extent that the Payors attempt to convert codes into plain English for members to understand the services rendered, then these plain English conversions will have to be re-written.

2.1.11 EOPs will have to be rewritten to use new codes

EOPs are Explanations of Payments and refer to the paper documentation that is sent to a provider explaining why or how a claim was adjudicated. Electronically, this is known as a Remittance Advice. Generally, the activity to remediate the process of creating these documents will have to be the same as at (2.1.10) above.

2.1.12 Any Claim reports that contain the ICD codes

All reports will have to be modified to accept the larger codes. This includes identify the correct information, modifying the field attributes in the report to accept this, and any impact that the difference between ICD-9 and ICD-10 might have on the values reported.

For example, if there are multiple ICD-10 codes for one ICD-9 code, then the number of instances of the ICD-9 code will be greater than the number of instances of any one of the equivalent ICD-10 codes. This does not mean the total number of diagnostic codes is less; it just means that the total is spread out over more ICD-10 codes. If the reader is not aware of this and/or if the totals are not displayed, this can give a misleading impression.

2.1.13 Any claim letters that rely on code sets

Some letters are generated automatically when certain codes are identified. For example, if the code indicates a condition that could be caused by an accident, then a letter inquiring about third party liability will be generated. Similarly codes that suggest a pregnancy may cause the generation of a kit informing the mother or the treating physician of benefits and rules related to maternity.

These auto-generated letters and the basis on which they are generated will have to be identified. If ICD-9 codes are the basis for any of these letters then the application generating the letters needs to be modified.

2.1.14 Hardware, software, and forms used to facilitate scanning and imaging of claims

One way of automating the process of receiving paper claims is to scan these. Some scanning processes merely create a digital image of the information received and this is then stored in a database for someone to retrieve and read. These images can then be presented to claim examiners for manual entry into the claim system.

More and more, however, payors are using software that actually reviews what is being scanned. These processes involve actually "reading the information" on the claim form using "Optical Character Recognition" (OCR) software. For payors using OCR software, the fact that the ICD-10 codes are bigger and use different codes will necessitate a re-evaluation of both the software and the business operations supporting these processes.

The software needs to be re-calibrated to recognize that different field lengths mean data is not exactly where it was previously expected and that codes read can have a different meaning. Business procedures typically are adopted to validate the quality of the scanning and OCR process. These procedures will have to be updated to address the changes in the OCR process brought about by adding the ICD-10 Codes.

Complicating this is the fact that the OCR scanning process will have to be able to continue to accept ICD-9 codes for as long as 24 months after the conversion to ICD-10. This is because many payors will accept a claim for services from providers for up to 24 months after the claim was incurred. So claims with ICD-9 Codes may appropriately be submitted for up to 24 months after the adoption of the ICD-10 Codes.

2.1.15 Handling claims during transition period

Health plans will have to develop processes and procedures for handling claims during the period of transition from one code set to another. This will involve trying to identify likely problems in advance and creating ways to address these before they happen.

2.1.16 Process for getting claim into system

Generally payors use one or more of the following processes to accept claims and enter them into their systems:

- Scanning
- EDI
- Manual processing

The processes by which claims are accepted by the claim system will need to be evaluated. The impact to scanning and imaging processes was dealt with generally above and EDI processes will be discussed later in this document.

However, here we refer to the process by which the claims area and claims system accept the information from these sources into their applications. Thus the interfaces through which claim data passes, the databases where data is stored, the screens on which claims are viewed during the input of claims all must be evaluated.

The typical results are that field sizes and edits for accuracy of information applied before the claim is adjudicated will need to be modified to reflect the new values that will be received.

2.1.17 Code auditing software

Many claim systems use external software to review codes for various purposes. Some software looks for fraud, others look for bundling or unbundling of claims, other applications evaluate codes for accuracy before the claim is submitted for processing.

This software will need to be updated. Often this software is supplied by vendors so the responsibility for updating the software lies with them. However the health plans have responsibility for loading the updates and testing them before these go into production.

2.1.18 Subrogation software

Similar to the auditing software above, many payors use software to identify when claims may involve third party liability and thus give rise to subrogation opportunities. This software also will need to be updated and the updates loaded and tested.

2.1.19 Consultants and others participating in claim reviews

Payors are often subject to claim process reviews. Some of these are voluntary – e.g. reviews to ensure compliance or to find ways to optimize business processes. Others are involuntary, such as Insurance Department audits.

Payors will be responsible for notifying these external parties of when and how the Payor is converting from ICD-9 to ICD-10 and how that will affect the payor's participation with the reviewer. This could require the reviewer to retrain their staff, update software tools, and/or find ways to map old data using the ICD-9 to the newer data using ICD-10 code sets.

2.2 Product Development

Product development for the purpose of this discussion is the process of configuring benefit tables within payor systems so that claims and provider fees can be adjudicated and paid. Benefits are established by evaluating codes and determining which will pay and under what circumstances. This is a tedious process and will be made more so by the expansion of the number of codes that will be available in the ICD-10 Code Set.

2.2.1 Need to reconfigure benefit designs

Whenever a new product is created or a group sold that has a variation on benefits, a new benefit table is set up. These benefit tables use ICD and CPT codes to determine what are covered services.

Adoption of the ICD-10 Code Set will require modification of all of these benefit tables to incorporate the new ICD codes. Given the difference between the ICD-9 and ICD-10 codes, some time and effort will be required to evaluate the ICD-10 codes and determine which ones apply and how.

Reconfiguring benefit designs is not a process that is automated in every case. Some vendor systems and particularly with older systems or "homegrown" systems, do not have tools that allow for mass updates and changes. This could result in health plans having to assign staff to manually reconfigure and recode benefit designs.

This is very tedious and requires staff with special skill and knowledge of the application. Existing benefit coding staff will likely be dedicated to this project for an extended period of time to code, test, and correct errors in coding.

Additional time will be spent as plans determine how to best utilize the richer information in the ICD-10 codes to enhance benefit design and claim processing. This analysis will occur before the coding can begin and will require more testing to allow Plans to determine what the real effect of such changes will be.

2.2.2 Tools used to determine co-pays, coinsurance, other accumulators

Tools within an application used to determine when co-payments apply and how much they are will also have to be updated if ICD codes are used. The same is true of certain accumulators that total up services rendered.

In the case of the co-payments, these are tied to codes that determine the nature of the service. For example, an office visit that is part of an annual check up might have a lower co-payment as part of a program to encourage wellness activities by a member. The ICD codes used in this process will have to be modified to indicate which activities are entitled to lower or higher co-payments.

Certain services, such as physical therapy, might have a limit on how many can be rendered under a benefit program. ICD codes might be used within the benefit tools to indicate which services these are.

2.3 Provider Contracting

Provider contracting describes the process of adopting new fee schedules that accommodate the ICD-10 Codes. This involves determining what new fee schedules should be used, communicating these to providers, negotiating the rates, configuring the final fee schedules in the administrative systems, integrating these into the claim system, and ancillary issues like pay for performance programs.

Completing this work will be challenging. Adopting new fee schedules requires a detailed analysis of the new codes and determining how to price them. For any health plan that wants to take advantage of the richer detail embedded in the codes, there is not a one to one or one to many correlation from ICD-9 to ICD-10. Rolling out new fee schedules will take months to complete. Then the final fee schedules have to be loaded into systems, linked to the claim process, and thoroughly tested to ensure that the work was done correctly and claims pay properly.

2.3.1 Provider contracts will have to be modified

Provider contracts often include fee schedules where medical codes are listed and the reimbursements for those codes are designated. These contracts may also have other special arrangements defined in the agreement, such as higher reimbursement levels for certain services at certain locations or spelling out standard codes the provider should or should not bill.

To the extent that these agreements utilize ICD-9 codes, then the codes must be modified to reflect the ICD-10 codes instead. Fortunately, fee schedules are often attached to contracts as Exhibits or Appendices. Where this is true, payors will have to reissue new Exhibits or Attachments with the correct codes. If the codes are specified in the body of the contract, then specific language amending the terms affected must be issued.

Regardless of whether the health plan is just rolling out new fee schedules or a new contract, the process will take a number of months for any managed care health plan to complete.

Creating a new fee schedule will involve getting a thorough understanding of the new code set, and then configuring and testing various fees. This will not be a simple substitution on a one-to-one basis because there are often many ICD-10 codes for a single ICD-9 code. Nor is this a "one-to-many" mapping because given the richer data in the ICD-10 codes. Payors will invariably want to take advantage of this and price codes based on the variation portrayed by the data, assigning higher or lower reimbursement rates perhaps based on levels of severity or complexity indicated by the new codes.

Throughout the process of developing the fee schedule, there will be extensive testing of the fees. This will be done to make sure that the changes are "cost neutral." Neither payors, nor their customers, will want to see an increase in claim payment costs resulting solely from adoption of a new code set.

Once the numbers for the fee schedule are determined, documents have to be drafted, approved, go through legal review, get printed, and then mailed. Once the fee schedules are sent out to providers, payors generally will have some form of educational process to inform providers of what is embodied in the agreements.

If payor fee schedules include any variation in payment rates, providers will take some time to evaluate the impact of these on their revenues. Invariably, this will give rise to providers complaining to and negotiating with the payors whenever providers feel their revenue streams are being impacted negatively. Realistically, not every doctor or hospital will be in a position to negotiate, but many will and this process will be time consuming.

Consider too that adoption of the ICD-10 code sets will have a specific deadline applicable to all payors. This means that every payor will be rolling out new fee schedules within a short time frame of one another. This will significantly impact the ability of providers to analyze these documents and negotiate them.

2.3.2 Modifications to provider reimbursement tables and links to claim systems

After the new provider contracts and/or fee schedules are agreed to by providers, the systems and tables that contain the information about provider reimbursement levels must be modified. Similarly, the link between these systems and tables and the systems that process claims must be modified. These modifications will reflect three types of changes.

First, changes need to be made to expand field sizes and attributes to permit the ICD-10 to reflect the new fees. Then the new fees will have to be loaded into the tables within the application. Finally, triggers will have to be modified so that the claim system knows when to call on the ICD-9 versus the ICD-10 fee schedules (e.g. for services rendered prior to the date on which the ICD-10 codes take effect).

These applications are typically owned by provider relations departments and are called upon by claim systems either to feed reimbursement tables within the claim applications or to provide the reimbursement information to the claim systems as needed to process claims. It is critical that this data be correct for claims to be processed and paid correctly.

Similarly, this information is used for other informational purposes such as answering inquiries from providers or data analysis within the payor organization.

2.3.3 Pay for Performance Programs utilize claim information

The underlying logic used to measure performance in pay-for-performance programs will have to be modified. These are based on analysis of claim information and medical records. The current applications, processes, and contract language is based in part on ICD-9 codes. Sufficient ICD-10 data will have to be collected to develop new ICD-10 based models of performance.

2.4 Provider Relations

While a health plan may have a business area called "Provider Relations" that is also responsible for provider contracting activities, the two subjects are separate here. The term "provider relations" refers to the business processes associated with receiving and addressing provider inquiries and concerns, communicating with providers generally, and overseeing their performance.

2.4.1 Process by which information is looked up to respond to provider inquiries about claims and benefits

Provider Relations processes often involve interaction with providers to look up the status of claims and reimbursements. Other questions may involve whether benefits are covered under an individual's policy or whether a provider can perform a specific service under their contract with the payor. Some health plans have provider relations departments to answer these questions. Other plans allow claim units to answer claim specific questions. So the focus of this discussion is on the processes and applications that support them not the business units. The impacts to these processes are multi-fold:

2.4.2 Applications used to look up information may need to be modified

To the extent that these applications utilize or depend upon ICD code sets, they will have to be modified. This can include modifying the field attributes within the application(s) to accommodate the different code set characteristics. It can also mean modifying the way that codes are read and interpreted, if these are translated into plain English for easier readability by the user.

2.4.3 Processes involving responding to questions need to be updated

Any changes to the applications or the methods of finding and using data to respond to inquiries will necessitate updates to the processes and procedures followed.

2.4.4 Personnel looking up information need to be retrained

Changes in the codes presented or in the processes and procedures followed will necessitate retraining of staff on these changes.

2.4.5 Claim history

Departments within a health plans may use different methods for looking into claim history. For example, the claim department may use the claim system itself, while the provider relations area may use a different system. If so, then that system must read both the old and new ICD codes and present, convert, or map them as needed to present data.

2.5 Communications:

2.5.1 To educate providers on what Payer is doing to comply

Payors must set out a plan for communicating to providers generally how the payor intends to comply with the regulation. This plan should indicate what communications are expected and when they should be sent.

Payors should expect to offer a discussion of how the payor's plans will impact the relationship between the payor and the provider and generally 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.

As part of these communications, payors would be wise to communicate to providers in advance of issuing new contracts, or mass amendments to contracts with revised fee schedules. These communications should describe how the fee schedules will change and why.

To carry out these communications, the health plan staff will have to draft articles, letters, and other forms of communications. These will then have to be sent to the providers in some form or fashion. Health plans have a variety of communications they send to providers today – newsletters, bulletins, etc. – that can be used as the vehicles for these communications.

Plans will also have to be prepared for feedback from the providers and their representatives. Payors will hear back from individual providers, provider trade associations, regulators, legislators, and even lawyers and the courts.

2.5.2 To set out rules and timeline for activating new Code Sets and reimbursement levels

Whenever new codes take effect, there is a cut off date. Under the HIPAA Regulations, when code sets change over this occurs on a specific date. Claims incurred prior to that date are submitted with the old codes. Claims incurred after that date are to be submitted with the new codes.

New reimbursement schemes will likely take effect the same way, with reimbursement levels changing when the code sets do.

While this is stated in the regulations, the interaction on specific claims is between payors and providers. Therefore, payors must communicate these rules to providers.

2.5.3 Modify previously issued provider documentation

Any previously released provider documentation will likely need to be updated. This includes newsletters, provider manuals, online communications, and anything else that includes coding.

Payors issue many different communications to providers that utilize ICD code sets. These include communications serve a variety of purposes. Some, like provider manuals with information about the payor's rules, can be quite lengthy. Payors must evaluate these documents to determine the extent to which ICD Codes are used and determine whether these can be updated or if they have to be replaced.

2.5.4 Provider portal on payor website may require modifications

Provider portals on payor websites offer similar information to what is delivered via telephone calls to provider relations areas. However, the portals will require evaluation and possible modification.

The pages used to present this information (and systems behind them) may need to be modified to accept the different attributes of the ICD-10 Code Set. Some payor websites also call different data sources for the information presented on the provider portals than are used by those answering the phones (plans may have to aggregate data from different back end sources into one database or to remove the demands of responding to web inquiries from the core applications). If so, these will need to be evaluated to ensure that they can support the ICD-10 codes.

2.5.5 Provider quality monitoring may have to be adjusted to reflect the new codes.

Payors have quality monitoring programs to oversee provider performance. This typically involves evaluating diagnostic and treatment codes to determine whether providers are performing adequately.

Payors should evaluate their current measures and how the new codes affect those. The impacts can simply require changing the processes and tools to reflect the new codes. However, payors will be remiss if they don't look at the additional information inherent in the new codes to determine how this can be used to improve the quality monitoring processes.

2.5.6 Any provider reports that uses the codes

Reports on provider activity that use ICD codes will have to be identified and evaluated. The capturing of information and presentation of these codes may need to be modified to utilize the new codes.

2.5.7 Any provider letters that uses the codes

As with the reports, canned letters that utilize ICD codes will have to be identified and evaluated. Any process by which certain codes trigger the generation of a letter or by which codes are inserted into the text of the letters, as well as the presentation of these codes in the letter, may have to be modified to utilize the new codes.

2.5.8 Internal tools, policies, desk level documents used by staff

Staff will develop internal tools, policies, and desk level documents to make various processes and activities easier to accomplish. Any of these which utilize ICD codes must be updated, modified, or replaced.

2.6 Customer Service

While customers may not have as much knowledge of ICD codes as providers, the areas within a payor that manage customer relations will have challenges similar to those of the Provider Relations areas. For example the impact of the ICD-10 codes on processes related to looking up claims, answering questions, and communicating with members about what is going on, or modifications to member portals will be similar.

2.6.1 Process by which claims are looked up

Customer Relations processes often involve interaction with members to look up the status of claims and reimbursements. Other questions may involve whether benefits are covered under an individual's policy. The impacts to these processes are multi-fold:

2.6.2 Applications used to look up information

If applications utilize or depend upon ICD code sets, they will have to be modified. This can involve modifying field attributes within applications to accommodate different code set characteristics. It can also mean modifying the way codes are read and interpreted, for example if these are translated into plain English for easier readability by the user.

2.6.3 Processes involving responding to questions

Any changes to the applications or the methods of finding and using data to respond to inquiries will necessitate updates to the processes and procedures followed.

2.6.4 Retrain personnel looking up information

Changes in the codes presented or in the processes and procedures followed will necessitate retraining of staff on these changes.

2.6.5 New vendor software may be needed to facilitate translations of codes

For individual health plans, it may prove daunting to try to develop plain English conversions of the ICD-10 codes for internal systems. Therefore, this may require purchasing and installing a vendor system, if one becomes available. Installation of such software is not as easy as loading a CD, like one might do at home.

First, there will be more than one desktop using the software. Many payors have the ability to administratively “push” software to desktops so it probably will not be necessary to load this at every desktop. Alternatively, a payor may want to integrate or otherwise link this software into their customer service application. That can be a more complicated process.

Either way, the software will need to be tested in the payor’s environment to make sure that it operates properly and does not interfere with other applications.

2.6.6 Claim history will have to be mapped from old codes to new

Health plans might have different applications looking into claim history for different purposes. For example, the claim department may use the claim system itself. The customer service area may use a different system. If this is the case, then that system will need to be able to read both the old and new ICD codes and present, convert, or map them as needed to present historical data in a fashion that permits the customer service representative to answer questions from the member.

2.6.7 Communications to members on the migration to ICD-10 Codes

Payors should create a plan for communicating to providers what is taking place with regards to the ICD-10 Code Set and the payor intends to comply with the regulation. This should include a discussion of how the payor’s plans will impact the relationship between the payor and the member and the payor and providers. Such communications should include a timeline of when member should expect to see activities.

To achieve this, the health plan staff will have to draft articles, letters, and other forms of communications. These will then have to be sent to members in some form or fashion. Health plans have a variety of communications they send to members today – newsletters, bulletins, etc. – that can be used as the vehicles for these communications.

2.6.8 Addressing calls and inquiries

Because plans will be communicating to doctors and members in advance of the date when the ICD-10 Codes go live, and because the media will be covering this, members will contact health plans for information. Certainly the volume of inquiries will increase the closer one gets to the date.

Being prepared for this will require prepared letters and phone scripts for customer service representatives. It may also require increased staffing for customer service areas to field the volumes of calls and letters.

2.6.9 May require changes to member portal where members

Member portals on payor websites offer similar information to what is delivered via telephone calls to provider relations areas. However, the portals will require evaluation and possible modification.

The pages used to present this information (and systems behind them) may need to be modified to accept the different attributes of the ICD-10 Code Set. Some payor websites also call different data sources for the information presented on the member portals than are used by those answering the phones. If so, these will need to be evaluated to ensure that they can support the ICD-10 codes.

2.6.10 Member communications that utilize ICD code sets, like canned letters

Payors must evaluate these documents to determine the extent to which ICD Codes are used and determine whether these can be updated or if they have to be replaced. Also, Plans will have to focus on ensuring that communications are in "plain English" and not confusing to members.

2.6.11 Consumer Directed Health Care tools

It is important to note that tools created to support consumer directed health plans will also need to be updated. This includes Nurse Hotlines that support such members, written communications, and online Personal Health Record and other tools, to name just a few. While some of these activities may appear to overlap areas mentioned previously, many health plans have tools that are unique to these programs. Furthermore, between now and when the ICD-10 Code Sets take effect, Consumer Directed Health Plans will grow in popularity and the number and variety of tools supporting these will increase. Thus it is worth citing this area specifically.

2.6.12 Internal tools, policies, desk level documents used by staff

Staff will develop internal tools, policies, and desk level documents to make various processes and activities easier to accomplish. Any of these which utilize ICD codes must be updated, modified, or replaced.

2.7 Medical management

Medical management is a broad area that covers many activities such as:

- Pre-authorization and pre-certification
- Medical necessity and medical appropriateness reviews
- Case management
- Disease management
- Research and analysis
- Provider quality oversight

Pre-authorizations and pre-certifications occur, as the name suggests, before a service is rendered. Medical necessity and medical appropriateness reviews occur after a service is rendered and when a claim is submitted. Case management and disease management are activities by health plans to assist when an individual has a known condition. Research and quality oversight occur after treatments are rendered and claims are processed.

Some of these activities appear similar but are actually very different and utilize if not different software, then at least different functions within the same software. Provider quality oversight and the research activities involve data mining and very different software.

2.7.1 Processes and applications to determine medical necessity and medical appropriateness

Processes to evaluate claims to determine whether services already rendered are medically necessary and medically appropriate utilize diagnostic codes. This involves software edits and audits, manual processes to identify claims that need to be evaluated. The evaluation of claims that could be denied is done manually.

There may also be software programs that provide guides or information to medical management staff responsible for determinations. Additionally, staff may have written policies, procedures, guidelines, books, and other materials to assist them in their tasks.

All of these, whether computer based software or edits in applications, or written materials, will need to be updated to reflect the newer code sets. Some of the modifications will be relatively simple field updates to be able to accept the different attributes of the ICD-10 Code Sets (e.g. longer codes with alpha and numeric codes).

The most challenging aspect of this will be to modify logic in the applications. The logic enables applications to recognize and act in a certain manner depending upon the code identified. It is not possible to do a one to one map of ICD-9 to ICD-10 codes so the logic will have to be re-written to recognize and act on the new codes. Since the new codes are rich in information embedded within them, the new logic will be more complex to take advantage of this.

Staff also needs access to the claim data and supporting information from the provider justifying the service or procedure. The claim information can be obtained by providing the reviewer with a view into the claim system. Or it may be transferred to the medical management software electronically. In the former case, changes to the claim system described previously will address the needs of the reviewer. If the data is transferred electronically to the medical management application, then the electronic process by which this is done, the location where the data is stored, and the screens used to view the data will have to be updated.

Supporting information currently is obtained in hard copy (e.g. by mail or fax) from providers. This will change shortly with the implementation of the claim attachment transaction. It is not possible to predict how the ICD-10 Code Set will affect software or processes that will develop to take advantage of this electronic data.

Whenever applications or materials change it is necessary to revise policies and procedures to reflect the changes and then train staff on the changes.

2.7.2 Process and applications used for pre-authorization or pre-certification of services

Processes to pre-authorize or pre-certify medical procedures or services before they are performed also utilize diagnostic codes. The more sophisticated programs contain complex decision trees that contain questions and guides to assist the reviewer in determining whether a service can be pre-authorized or pre-certified.

If the decision to approve is not clear, then a manual review must occur. The manual review may utilize software that provides guides or information to medical management staff responsible for determinations. Additionally, staff may have written policies, procedures, guidelines, books, and other materials to assist them in their tasks.

All of these, whether computer based software or edits in applications, or written materials, will need to be updated to reflect the newer code sets. Some of the modifications will be relatively simple field updates to be able to accept the different attributes of the ICD-10 Code Sets (e.g. longer codes with alpha and numeric codes).

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Whenever applications or materials change, it is necessary to revise policies and procedures to reflect the changes and then train staff on the changes.

2.7.3 Case management applications and processes

This typically occurs when an individual has a severe condition that involves complicated, expensive, or long term treatment. Health plan staff becomes involved in authorizing or certifying services in advance based on a course of treatment reviewed with the treating physician.

Processes and applications involve capturing and reviewing claims, and authorization, and medical history, benefit tables and accumulators, and permit clinicians to record notes and information about what services have been approved. Additionally, staff may have written policies, procedures, guidelines, books, and other materials to assist them in their tasks.

All of these will need to be updated to reflect the newer code sets. Some of the modifications will be relatively simple field updates to be able to accept the different attributes of the ICD-10 Code Sets (e.g. longer codes with alpha and numeric codes).

The most challenging aspect of this will be to modify logic in the applications. The logic enables applications to recognize and act in a certain manner depending upon the code identified. It is not possible to do a one to one map of ICD-9 to ICD-10 codes so the logic will have to be re-written to recognize and act on the new codes. Since the new codes are rich in information embedded within them, the new logic will be more complex to take advantage of this.

As stated previously, when applications or materials change, it is necessary to revise policies and procedures to reflect the changes and then train staff on the changes.

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