

# **ICD-10 Task Force**

## ***A Payor Perspective on ICD-10***

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*Disclaimer: The opinions expressed in this document are those of the presenter and not those of CIGNA Corporation either by association or intent.*

# Background – Paul Oates

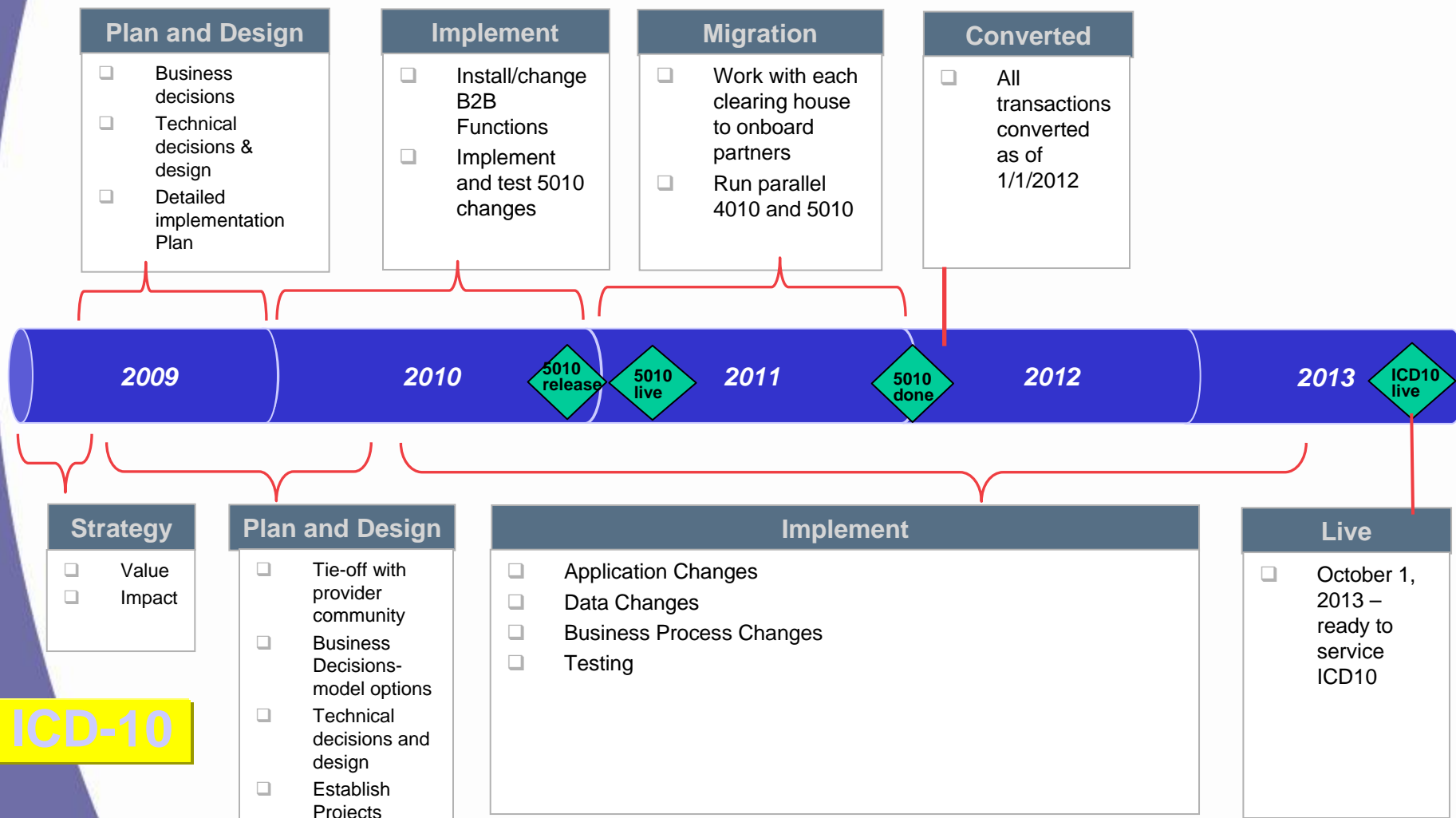
- Member HIMSS PHR Steering Committee (2009-2011) and Member PHR Value Workgroup
- Webinar: “How ARRA Will Change the Payor/Provider Relationship,” HIMSS, June 2009
- HITSP Finance and Administrative Domain Technical Committee, 2008
- Lead, 2008 Payor Roundtable, HIMSS
- Payor Representative, Annual Conference Education Committee, HIMSS, 2007-2009
- Chair, Payor Symposium 2007, 2008, 2009 Annual Conferences, HIMSS
- Nominee for HIMSS 2006 & 2007 Board of Directors
- Incorporator and Technology Co-Chair, eHealthConnecticut Regional Health Organization on behalf of former Congresswomen Nancy Johnson
- Chair, HIMSS Payor Special Interest Group
- HIMSS Standards Task Force
- Operations/Technology Workgroup, America’s Health Insurance Plans (AHIP)
- Personal Health Record Technical Advisory Group, AHIP
- Session Coordinator and Panelist: HIMSS Pay for Performance Symposium, HIMSS 2006
- Presentation: Integrating Payor and Provider Health Records for Care Coordination, HIMSS 2006
- Presentation: Standards as Catalyst for Payor-Provider Collaboration, HIMSS 2005
- Panel Presentation: Overcoming the Great Data Disconnect, HIMSS Summit 2005
- Panel Presentation: Health plan Incentives to Providers for EHR, 2004 Medical Records Institute

# Topics

- Typical Payor ICD-10 Project Timelines and Status
- Key Impacts on Payors That Impact Providers Too
  - Process, Reimbursement, Schedule
- Some Findings and Ah-has
- Worries

**5010**

# 5010 and ICD-10 Timeline



**ICD-10**

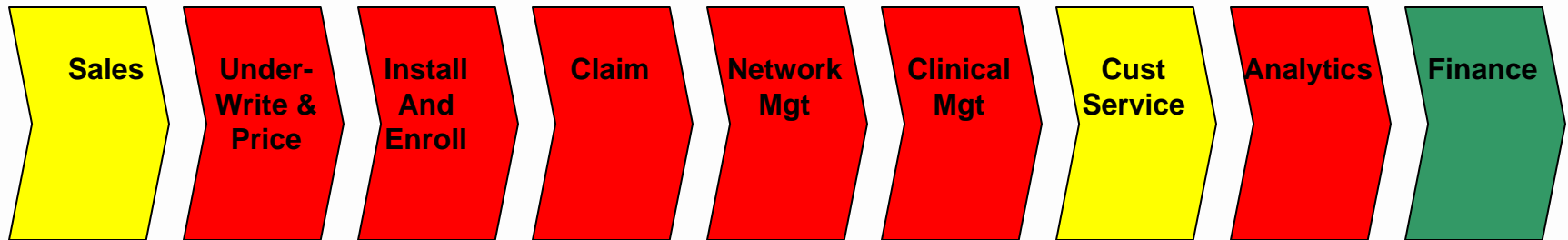
# Critical Success Factors

*Successful adoption of ICD-10 relies on several factors:*

- Once you get over the HIPAA 5010 hump, the business **must focus on ICD-10 planning** in 2010 at the latest
- **Determining the optimal solution mix for ICD-10 compliance** – dual process or cross-walk – is a key business decision informed by IT complexity
- **Cross-walks have hidden risks** including material impacts to Total Medical Costs and to Provider Reimbursement
- **Business and IT must engage together** to define the optimal solution

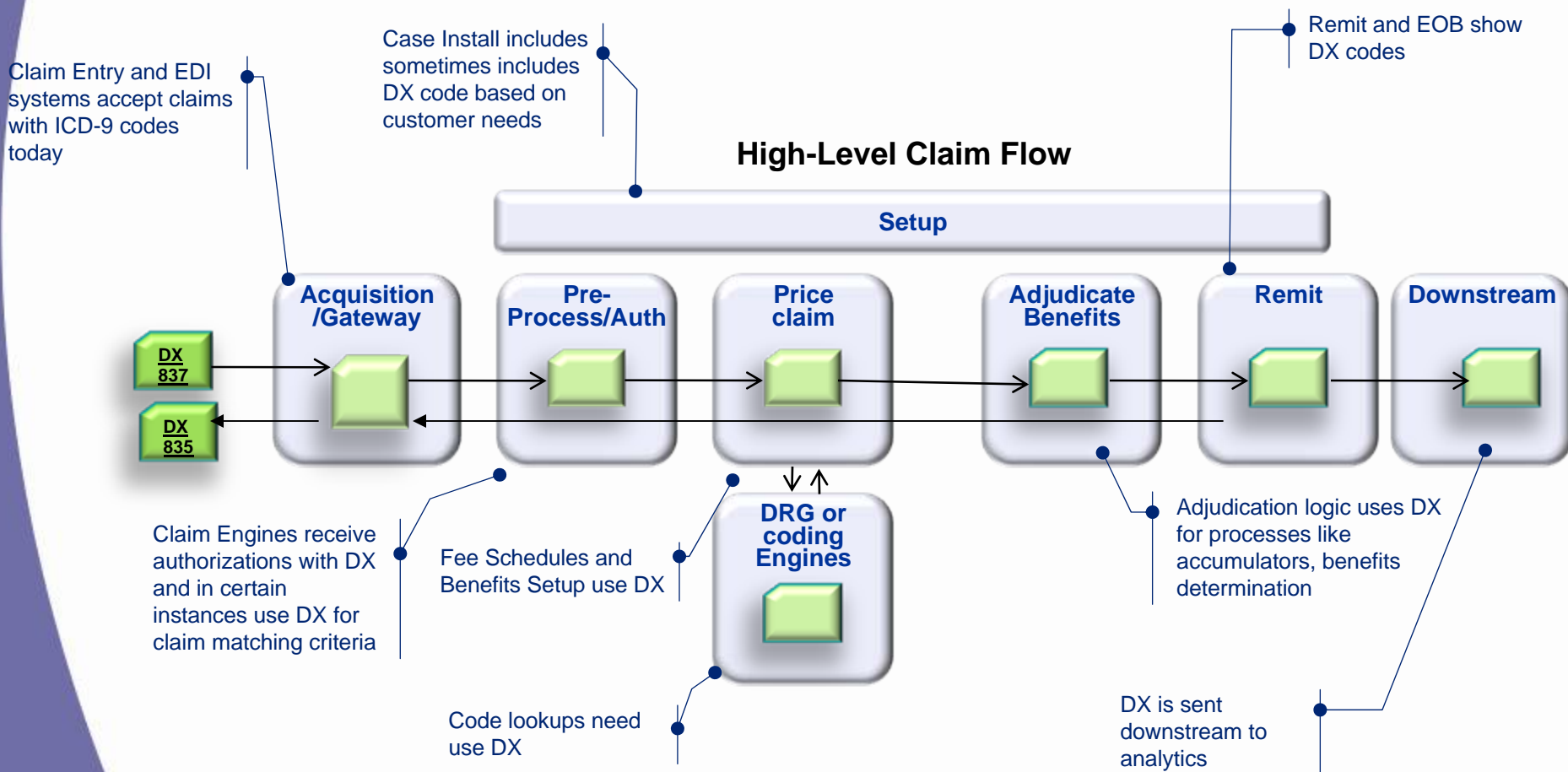
ICD-10 is a multi-million dollar impact to plan and execute necessary changes. It is more like a Y2K project than a compliance-oriented project.

# Health Plan Process Impacts

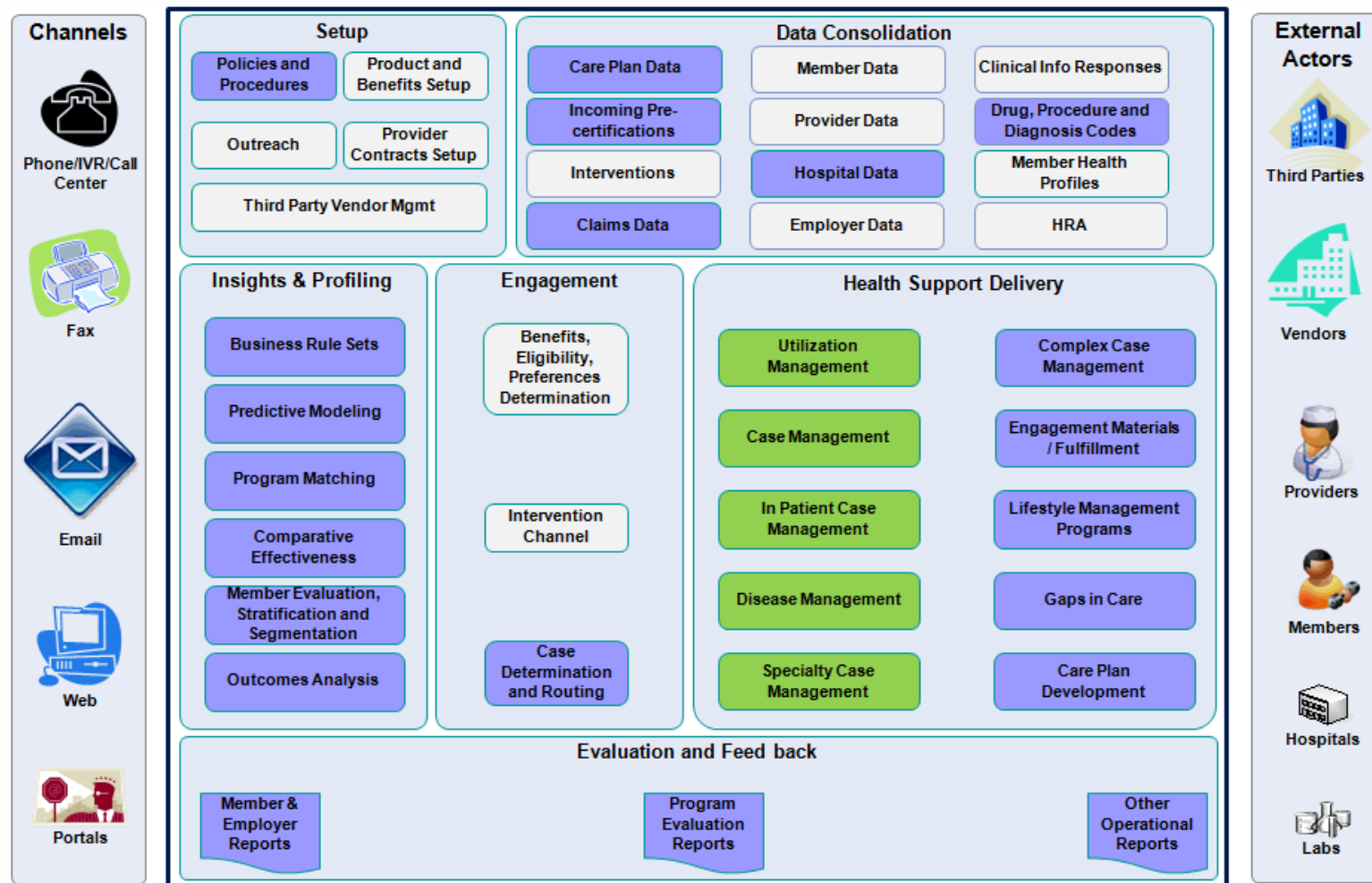


- Product design and corresponding benefit application during claim processing
- Case installation and enrollment
- Clinical processes – care coordination, analytics
  - and auth match during claim processing
- Network contracting and pricing changes
  - and impact during claim processing
- Analytics and reporting across business functions
- Technology across the enterprise

# Example Claim Impacts



# Example Clinical Impacts



**HIMSS**

*transforming healthcare through IT*

architects of change

# Process Implications

Selecting the correct business solution associated with ICD-10 is a key business decision.

# ICD-10 Solution Options

## Range of ICD-10 Solution Options

### Insulate Processes/Systems

Using a CROSS-WALK, convert inbound ICD-10 to ICD-9 for claim processing

#### Pros

- Minimizes impact on claim engines
- Mitigates against uneven adoption

#### Cons

- Some processes must function in ICD-10 'day-1' and ICD10 must be made available
- Total cost of ownership (industry estimates > 70,000 hours to validate COTS products)
- Business exposure from mistakes in crosswalk (> 10% of in-patient TMC is exposed to errors)

### Dual Process

Accept and process both ICD-9 and ICD-10

#### Pros

- Consistency in addressing the market across business processes
- Minimize business exposure from incorrect cross-walks and associated costs

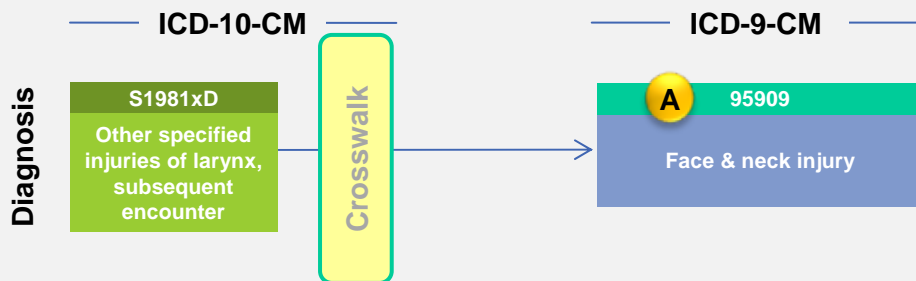
#### Cons

- Requires significant changes to claim engines
- Requires coordination across the enterprise

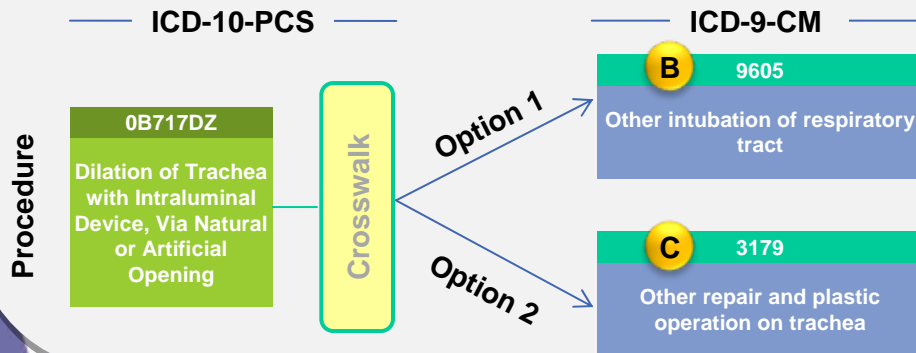
# The 'Cross-Walk' Conundrum

Cross-walks between ICD-10 and ICD-9, a central tenant of an 'insulate' strategy, can have a **material impact on reimbursement**. Decisions are required about mapping options.

## 1. Map Diagnosis Codes



## 2. Map Procedure Codes



## 3. Derive DRG for reimbursement

Option 1 - **A** + **B**  
DRG (v26): 914

Allowed Amount: **\$5000**

Option 2 - **A** + **C**  
DRG (v26): 909

Allowed Amount: **\$10000**

### Implications

- Health Plan Total Medical Cost
- Provider Reimbursement
- Patient Out of Pocket / Lifetime Max

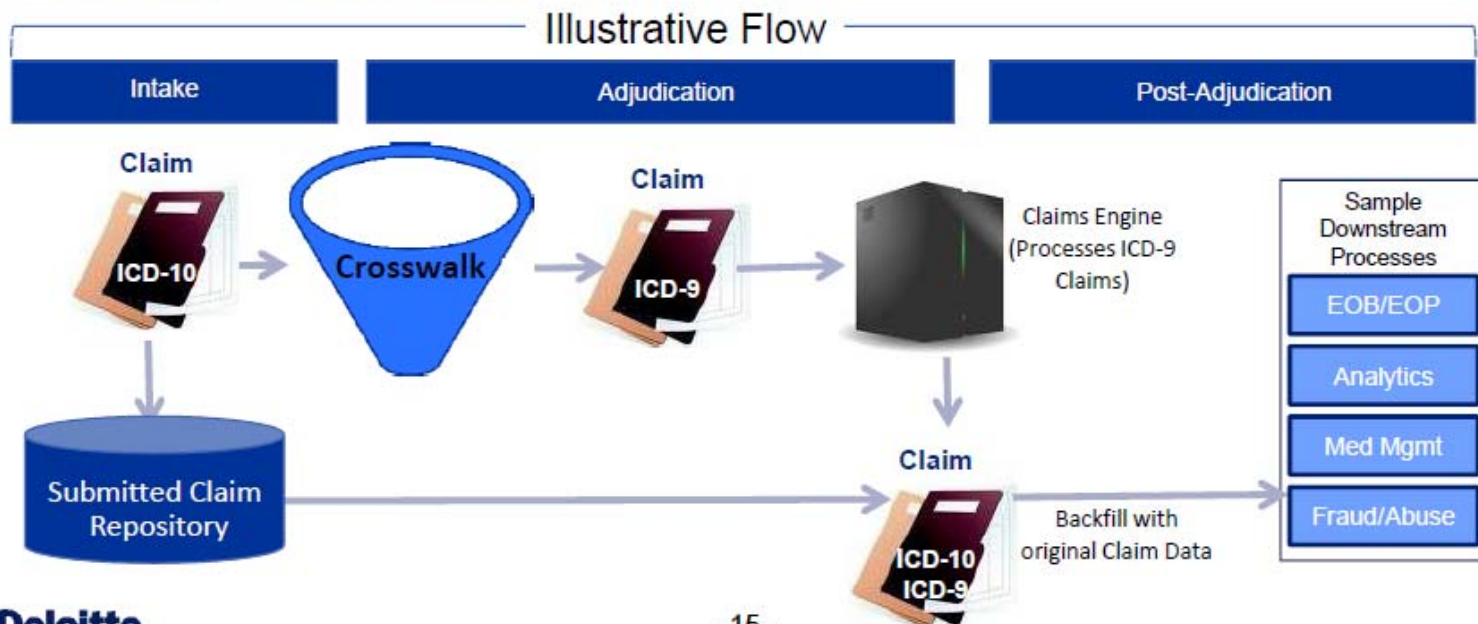
There is no industry standard to apply, and COTS cross-walk solutions still require > 75,000 hour of validation, and COTS claim engines are embedding cross-walks that will also require validation.

## Crosswalks: Positioning in the Claim Flow

*The location of a crosswalk dictates which codes are used throughout the claims lifecycle (impacting both technology and business process)*

### Key Considerations

- What codes are used for front end validation logic?
- When DRGs are updated against ICD-10, what adjudication discrepancies will arise if ICD-9 is still used?
- If crosswalking reduces the number of useable ICD-9 codes, how will analytics be influenced particularly with longer term longitudinal analysis or data grouping (products and benefits, clinical, contracting)?
- CMS's scenario is only one of many; how will multiple approaches even inside one organization influence key processes and how will multiple approaches across organizations impact the industry more broadly?

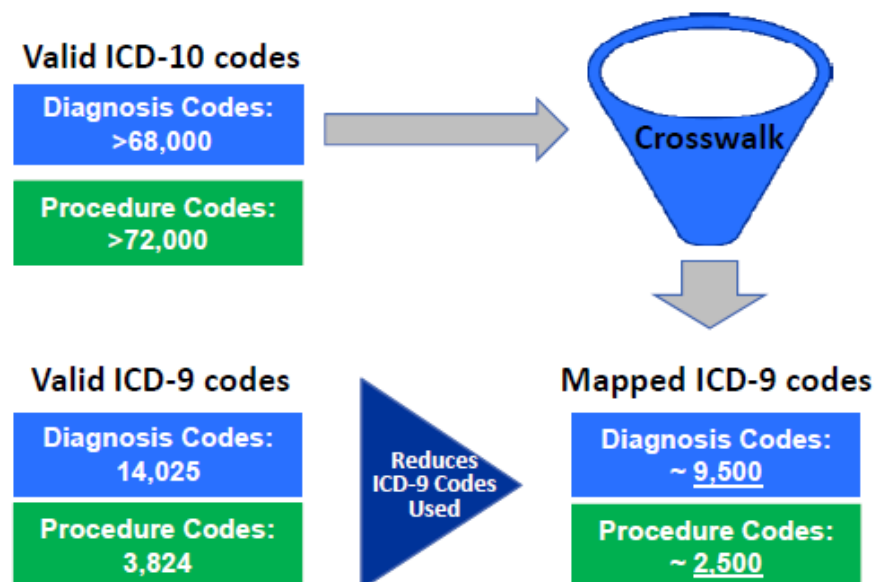


# Reimbursement and Medical Cost Implications

## Reimbursement Mappings – Relevance of Selecting Alternatives

*Using the Reimbursement Mappings will reduce the granularity of ICD-10 codes and eliminate a portion of the ICD-9 codes that are currently available*

- Using a crosswalk to map ICD-10 to ICD-9 significantly reduces the total volume of codes that are leveraged in the adjudication process
- CMS's Reimbursement Mappings would eliminate approximately 35% of ICD-9 diagnosis codes and 40% of ICD-9 procedure codes for use in key processes such as product design, contracting, benefits, claim adjudication, clinical and finance

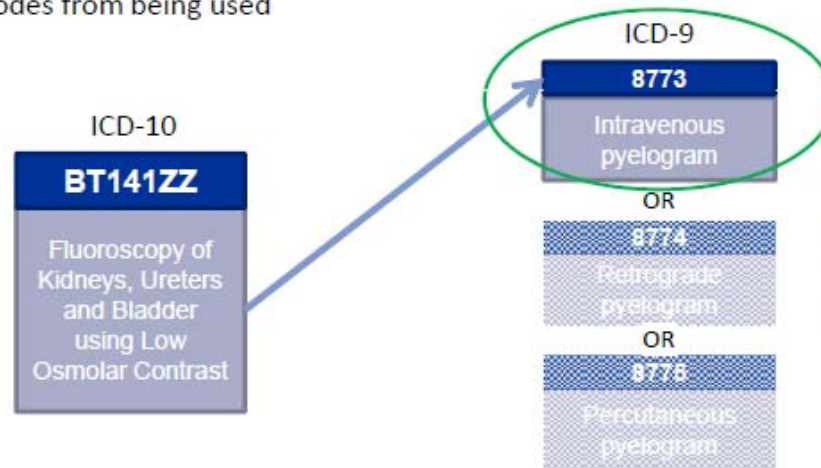


## Reimbursement Mappings – Eliminating a Portion of ICD-9 Codes

*Automating mapping rules in a crosswalk requires removing alternatives and effectively eliminates a portion of ICD-9 codes that are currently received*

### Example:

- The ICD-10 code for 'Fluoroscopy of Kidneys, Ureters and Bladder using Low Osmolar Contrast' maps to three distinct alternatives
- CMS chose to map to the ICD-9 code that was most frequent in their sample data, preventing the other two codes from being used



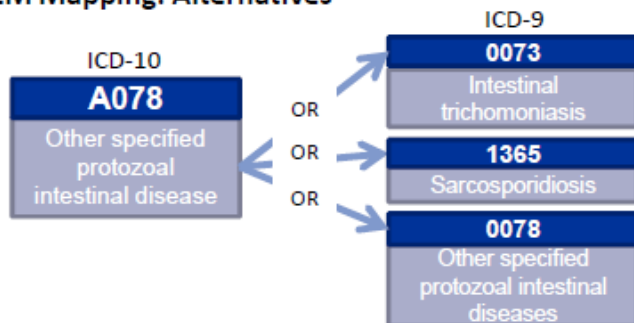
Each health plan will analyze their own claim data to determine the most appropriate mapping

The elimination of ICD-9 codes used in the adjudication process will influence every process that relies on the current granularity of the code set

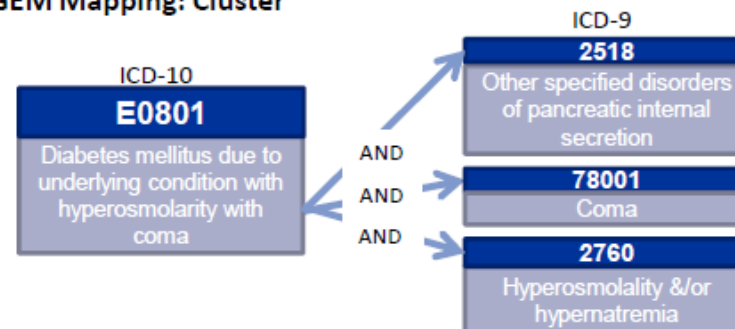
## Reimbursement Mapping Overview

Each ICD-10 code is mapped to exactly one ICD-9 code or cluster of codes however multiple ICD-10 codes can still map to the same ICD-9 code

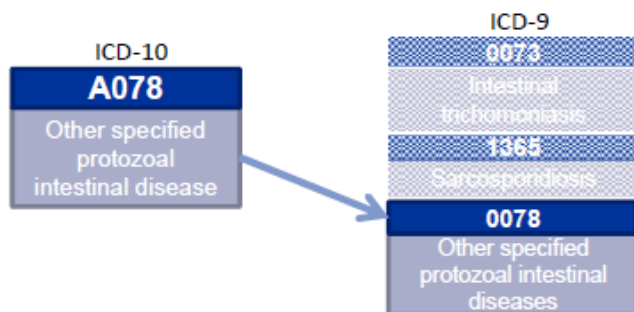
### GEM Mapping: Alternatives



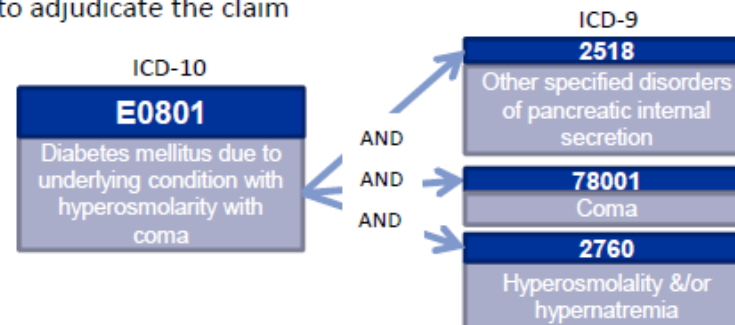
### GEM Mapping: Cluster



**Reimbursement Mapping:** Once a mapping is chosen, the other options will never be used



**Reimbursement Mapping:** Replaces a single ICD-10 code with multiple ICD-9 codes which may impact system ability to adjudicate the claim



*The volume of in-patient contracts **underscores the complexity of implementing ICD-10.***

## External Provider Partner Impacts

Type of contract has a meaningful impact on reimbursement impact

- Impacted: MS-DRG, AP-DRG, CMS-DRG, case rate
- Somewhat impacted: per diem
- Not impacted: percent of charge

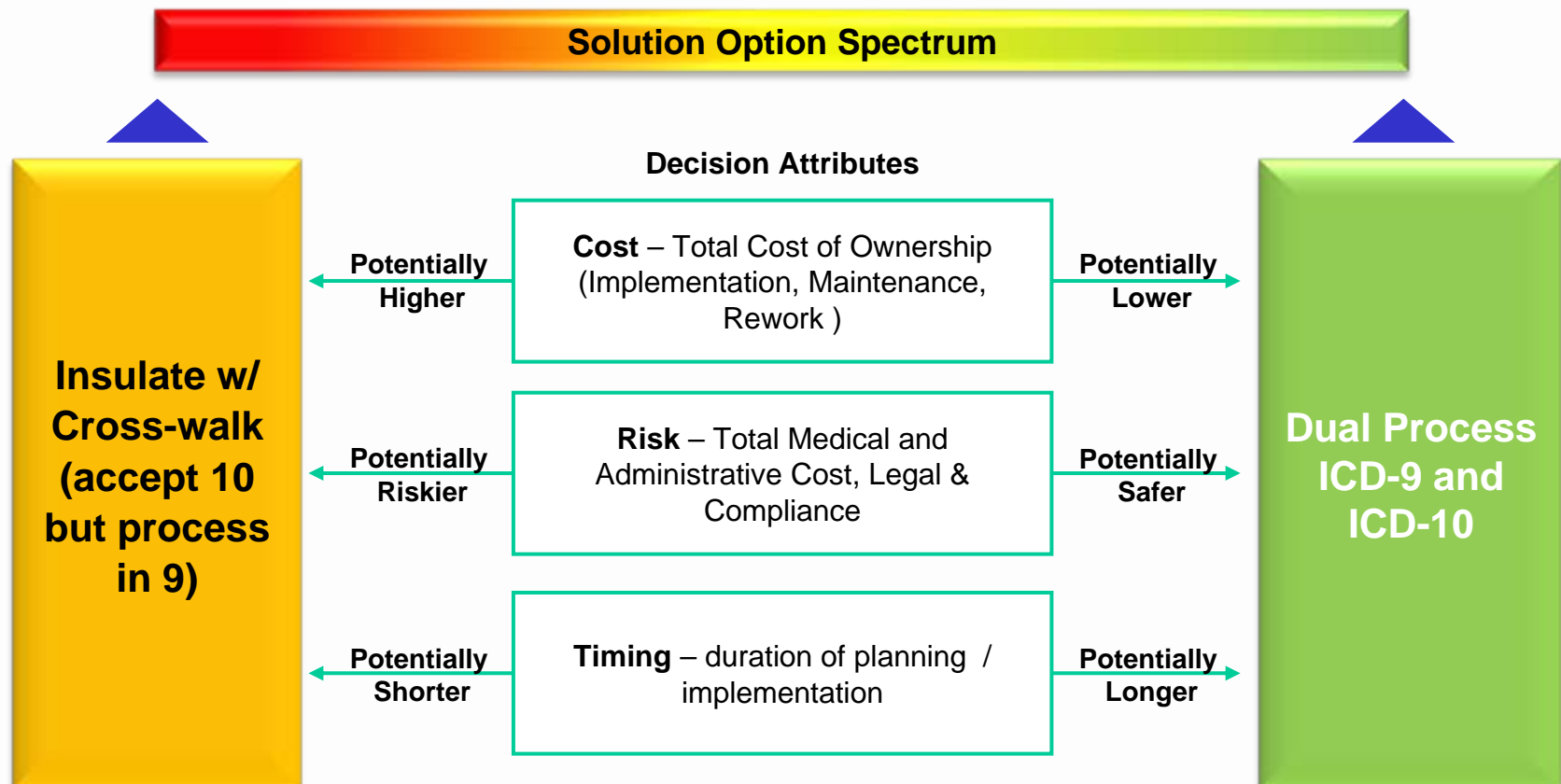
Payors are looking at total medical cost and the number of contracts in each type to forecast impacts. Modeling is one way to do this. Key: predict impact on a provider's current contract so partners can identify and share resolution. Goal: neutral impact.

So, the cross-walk strategies above impact providers too.

# Schedule and Cost Implications

*While it is tempting to do a “cross walk,” dual processing may also be a reality to ensure accuracy, especially during run-out of ICD-9.*

# ICD-10 Solution Options Analysis



# Other Notes

- There is a significant run-in and run-out time period where we will get both codes
- Some systems won't make the cut and will need to be sunset
- Claim and contract focus now, but the next big thing: Analytics impact.
  - What to with history: claims, quality measures, patient history
  - Changing and testing algorithms and content

# Worries

- The perfect storm
  - HIPAA 5010, ICD-10, EHRs and effective use, health reform
- Will we receive ICD-10 codes on schedule?
  - Or, will receive *meaningful* ICD-10 codes?
- Impact on provider relationships, including reimbursement
- Concern about consistency and impact on providers due to high likelihood of differences in implementations
- Implementation execution across the entire supply chain and timing of getting testing done (provider → clearinghouse → payor and return)

