ICD-10's Impact on Noncovered Entities: Many Reasons Will Lead to Voluntary Upgrades

By Sue Bowman, RHIA, CCS, and Nelly Leon-Chisen, RHIA

The ICD-10-CM/PCS final rule requires HIPAA covered entities adopt the ICD-10-CM and ICD-10-PCS code sets by October 1, 2013. Adoption is not required for noncovered entities such as property and casualty insurance health plans, workers' compensation programs, and disability insurance programs that submit noncovered transactions like paper claims, quality reporting, and patient assessment data sets.

However, this does not mean that noncovered entities will not adopt or use ICD-10 in noncovered transactions. For many noncovered entities, the benefits of adopting ICD-10 will outweigh the challenges of implementation. (For an example of one noncovered entity's plans to transition, see the sidebar below.)

The Benefits for Noncovered Entities

The Centers for Medicare and Medicaid Services (CMS) plans to work with noncovered entities to encourage ICD-10 use. CMS notes that it is in noncovered entities' best interest to adopt the ICD-10 code sets.[1]

The increased detail in ICD-10 provides significant value to noncovered entities. For example, the expanded injury codes will be useful to automobile insurance and workers' compensation programs.

Noncovered entities stand to achieve the same benefits of using more detailed, up-to-date code sets as covered entities, including better data for:

- Measuring the quality, safety, and efficacy of care
- Designing payment systems and processing claims for reimbursement
- Conducting research, epidemiological studies, and clinical trials
- Setting health policy
- Operational and strategic planning and designing healthcare delivery systems
- Monitoring resource utilization
- Improving clinical, financial, and administrative performance
- Preventing and detecting healthcare fraud and abuse
- Tracking public health and risks

In addition, ICD-9-CM will no longer be maintained once ICD-10 is implemented, meaning the usefulness of the ICD-9-CM code set will rapidly decline. ICD-9-CM products and resources also will become increasingly difficult to obtain.

Those noncovered entities that continue to use ICD-9-CM after the ICD-10 compliance date will compromise their ability to compare data with covered entities.

Aligning Paper and Electronic Claims

Technically speaking, the HIPAA standard applies to electronic claim transactions, not paper claims. However, the vast majority of healthcare claims are submitted electronically, except for rare occasions where unusual circumstances may require a provider to compile a paper claim. Small providers may still be submitting paper claims.

In these situations, payers may create business rules requiring alignment of paper and electronic claims so that both are submitted using ICD-10 codes.

It would be extremely expensive for providers and payers to maintain dual processing systems to continue using ICD-9-CM codes for paper claims past the implementation date for electronic claims. Dual coding systems would require payers maintain all their systems (e.g., processing, adjudication, risk adjustment, actuarial, statistical reporting) in both ICD-9-CM and ICD-10.

The National Uniform Billing Committee, the committee responsible for maintaining the integrity of the UB-04 data set, intends to follow the HIPAA code set rules for the preparation of paper UB-04 claims. The Uniform Billing Manual will indicate this change. While the UB paper claim is not subject to any national reporting requirement, CMS will likely issue instructions in its manuals.

Some states, such as Minnesota, have aligned paper and electronic reporting, and others are likely to follow. It is possible for someone to continue using ICD-9-CM codes on paper claims, but most providers would prefer to align the paper and electronic claims as much as possible.

It does not make sense operationally to prepare paper claims using ICD-9-CM while CMS requires claims be submitted to Medicare electronically using ICD-10. Providers will want to develop expert ICD-10 coders and it wouldn't be feasible to also maintain the ICD-9-CM expertise of their coders for the few paper claims they may submit.

Quality Measures Reporting

Another noncovered use of ICD-9-CM codes is quality measures. Many of the existing quality measures utilize ICD-9-CM as a byproduct of administrative claims data, if not for full reporting, at least for case identification. Continuing to express these quality measures in a coding system no longer supported by administrative claims data would negate the value of using coded data.

In addition, ICD-10's added clinical specificity provides more useful information to determine patterns of care. So organizations such as the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA) have already begun work to address the impact of ICD-10 on their processes.

A majority of the diagnoses and procedures used to define the current set of measures endorsed by NQF are specified using ICD-9-CM codes. In preparation for the transition to ICD-10, NQF took steps to examine the implications for its measure maintenance procedures and understand the impact of code transitions for the measurement community, particularly measure developers as they began to shape their processes to accommodate the necessary measure updates. NQF's goal is to ensure the specifications of its endorsed measure portfolio reflect the necessary ICD-10 codes and are ready for use by 2013.

In August 2009 NQF convened an expert panel to offer guidance and insight on the impact of this transition on quality measures and NQF's measure evaluation and maintenance processes. In October 2010, NQF released a consensus report based on the panel's recommendations titled "ICD-10-CM/PCS Coding Maintenance Operational Guidance."

The report includes guidance to address issues around equivalency of code lists and populations and the impact of code transitions on measure integrity, recommendations on best practices for approaching code conversion tasks for quality measurement, and operational guidance for NQF's measure submission and maintenance process involving multiple code sets. The full report is available at www.qualityforum.org/Publications.aspx.

NCQA is responsible for the development of the Healthcare Effectiveness Data and Information Set (HEDIS), which is one of the most widely used set of healthcare performance measures in the United States. HEDIS measures include several different coding systems, such as CPT, HCPCS level II, LOINC, and ICD-9-CM. Through its HEDIS expert coding panel, NCQA has started reviewing measures and identifying the ICD-10 codes that would affect those measures.

Other Affected Data Sets

Other noncovered uses of ICD-9-CM codes include data sets such as the Outcome and Assessment Information Set (OASIS) for use in home health agencies, the Minimum Data Set (MDS) used for nursing homes, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) used by inpatient rehabilitation facilities. The patient assessment instruments currently include ICD-9 codes.

CMS has already identified the effects ICD-10 will have on the business process and systems for OASIS, IRF-PAI, and similar instruments through the Transactions and HIPAA Code Sets final rule. The "CMS ICD-10 Planning" report prepared by AHIMA included these noncovered data sets and therefore are part of CMS's overall ICD-10 transition plans.[2]

Working with Noblis, the Office of E-Health Standards and Services analyzed the operational policies, processes, and systems of CMS's affected areas to determine the risks and work effort involved in transitioning to ICD-10. The "ICD-10 Impact Analysis for Planning and Implementation" report took a further look at the different assessment instruments collected by CMS and came to the conclusion that the more clinically accurate ICD-10 codes can improve the Develop and Utilize Assessment Tools process. This is the CMS process for the development, collection, and reporting of assessment instrument data for skilled nursing facilities, home health agencies, swing bed hospitals, and inpatient rehabilitation facilities.

CMS can take advantage of these opportunities by:

- Improving the ability to monitor patient care and healthcare quality. Upgrading the patient assessment instruments to collect ICD-10 codes from providers will provide CMS and its contractors with more visibility into patient conditions and services provided. This additional visibility will help CMS better analyze healthcare quality at the individual and population levels and give CMS the ability to better assess the clinical care a patient should receive and assess the quality of care provided by post-acute care facilities, leading to more cost-effective care.
- Providing better information for calculating payment rates. ICD-10 codes increase the ability to substantiate the medical necessity of diagnostic and therapeutic services, leading to improved reimbursement methodologies and facilitating more advanced payment systems (e.g., value-based payment systems).
- Enabling Medicare beneficiaries and other healthcare consumers to make more educated healthcare decisions. The improved ability to identify and track health outcomes with ICD-10 codes will lead to more accurate information on CMS's Web sites and allow consumers to make more educated healthcare decisions.[3]

Implementing ICD-10 at the Ohio Bureau of Workers Compensation

By Jean L. Stevens, RHIT, CCS-P

Workers' compensation plans are one of the few HIPAA exempt entities that are not mandated to convert from ICD-9-CM to ICD-10-CM/PCS. However, the Ohio Bureau of Workers Compensation (OBWC) is preparing to join the rest of the US in implementing ICD-10 on October 1, 2013.

ICD-10's Implications for OBWC

OBWC is a monopolistic payer that reimburses disability and medical payments for approximately 1.2 million active claims for work-related injuries. Annually it pays $799 million for medical services rendered by a variety of provider types and $1.1 billion for disability compensation to Ohio's injured workers.

OBWC processes bills for 250,000 outpatient hospital encounters, 5,000 inpatient hospital stays, 6,200 ambulatory surgery center procedures, and more than 2 million professional provider services on a yearly basis. It is responsible for reimbursing professional bills, which may include services rendered by physicians, chiropractors, nurse practitioners, physician assistants, physical and mental health therapists, psychologists, dentists, optometrists, opticians, orthotists, prosthetists, and durable medical equipment vendors.

In addition, OBWC uses a pharmacy benefits manager to process nearly 1.5 million prescriptions at a cost of $127 million.

Effective October 1, 2013, all OBWC HIPAA compliant providers will be mandated to submit ICD-10 diagnosis codes when billing most other payers. While OBWC could demand every bill it receives contain ICD-9-CM codes after the ICD-10 implementation date, it was determined that action would create an undue hardship for its providers.

OBWC's mission is to ensure access to quality care for Ohio's injured workers. The additional administrative burden that would be produced by forcing certified providers to bill OBWC differently from every other payer they contract with could cause some OBWC certified providers to rethink the relationship.

Senior OBWC staff determined that, in order to be able to conduct business as usual, conversion to ICD-10 is absolutely necessary. The fact that ICD-9-CM will cease to be maintained was a significant consideration. OBWC has neither the personnel nor the expertise required to attempt such a daunting undertaking. As new diseases are discovered, new codes must be assigned. Even if OBWC had the capability to create and maintain ICD-9-CM codes, some chapters have reached capacity, making it difficult to assign new codes in numeric sequence.

OBWC could accept ICD-10 codes and crosswalk those codes back to the ICD-9-CM claim allowance. However, that would require an internal mechanism be developed and maintained for that process to occur. Additional staff would also be necessary to ensure reimbursement could occur.

OBWC is a medical-legal payer system. That means the condition that is legally allowed as a diagnosis in the claim is typically the only one associated with reimbursable services. ICD-10 implementation will allow OBWC to report work-related injuries more accurately.

Currently, one FTE, a certified coder, is assigned to modify claim allowances to match the legal order narrative, which may include specific details such as the location of the injury. With the adoption of the more specific ICD-10 codes, that task will become partially eliminated, allowing the certified coder to perform other pertinent duties.

In addition, diagnosis coding for statistical reporting will be identical for OBWC as it is for other healthcare and government entities. If conversion does not occur, the bureau will need to crosswalk any report that contains ICD-10 codes back to ICD-9 codes in order to evaluate results.

OBWC's ICD-10 Implementation Plan

Certain diagnoses are allowed on OBWC claims, while others are not. Therefore OBWC personnel determined that ICD-10 implementation would be an expansive project, affecting nearly every division in the agency.

In April 2009 OBWC formed a steering committee to create a preliminary project charter and scope documents for ICD-10 implementation. Team members included a project manager from IT, a project manager from the medical services division, a business lead functioning as the subject matter expert, and a business member serving as the liaison to outside entities. The chief of the medical services division was named the sponsor of the project. The chief of managed care services was deemed the steering committee liaison.

The team began to meet every other week to work on details of the project. Roles and responsibilities for core members were defined. In August 2009 three team members presented a preliminary project outline to the OBWC governance committee for approval. The governance committee suggested an analysis be performed regarding ICD-10 conversion and implementation. Several members of the IT department assessed the various uses of diagnosis codes and associated touch points within the agency.

The preliminary analysis report assigned six phases to the project, each with a timeline and associated cost. Included in every phase were specific tasks, the area responsible for the tasks, and the hours necessary for the tasks to be performed. The core group designated key members from areas throughout the agency and held a kick-off meeting with approximately 30 staff in attendance.

The analysis document was discussed and preparation for implementation began. As other agency initiatives occurred, including the Medicare secondary reporting mandate, current staffing constraints were identified that would not permit complete adoption of the ICD-10 project timeline. It was determined that certain designated tasks within the project plan could be performed, but the overall plan for implementation would be delayed until January 1, 2011.

As the new year dawns, OBWC will initiate work in earnest on the ICD-10 implementation project, making it an agency-wide priority.

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Notes

1. Centers for Medicare and Medicaid Services. "ICD-10-CM/PCS Myths and Facts." April 2010. Available online at https://www.cms.gov/ICD10/Downloads/ICD-10MythsandFacts.pdf.
2. AHIMA. "CMS ICD-10 Planning. Initial Summary of AHIMA Executive Report." October 2008. Available online at https://www.cms.gov/ICD10/04_CMSImplementationPlanning.asp.
3. Centers for Medicare and Medicaid Services. "ICD-10 Impact Analysis for Planning and Implementation." July 22, 2009. Available online at https://www.cms.gov/ICD10/04_CMSImplementationPlanning.asp.

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