ICD-10 Implementation in a 5010 Environment Follow-up National Provider Conference Call

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ICD-10 Implementation

- October 1, 2013 – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)
  - No delays
  - No grace period

ICD-10 Implementation

- ICD-10-CM (diagnoses) will be used by all providers in every health care setting
- ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
  - ICD-10-PCS will not be used on physician claims, even those for inpatient visits

CPT & HCPCS

- No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
- CPT and HCPCPS will continue to be used for physician and ambulatory services including physician visits to inpatients

ICD-10 Implementation

- Single implementation date of October 1, 2013 for all users
  - Date of service for ambulatory and physician reporting
    - Ambulatory and physician services provided on or after 10-1-2013 will use ICD-10-CM diagnosis codes
  - Date of discharge for hospital claims for inpatient settings
    - Inpatient discharges occurring on or after 10-1-2013 will use ICD-10-CM and ICD-10-PCS codes

ICD-10 Implementation

- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013

- ICD-10 codes will not be accepted for services prior to October 1, 2013

ICD-9 Notice: The International Classification of Diseases, 9thEdition, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

ICD-10 Differences

- ICD-10 codes are different from ICD-9-CM codes
  - They provide greater detail in describing diagnoses and procedures
  - There are more ICD-10 codes than ICD-9-CM codes
- ICD-10 codes are longer and use more alpha characters
- System changes required to accommodate ICD-10 codes

Complete Versions of ICD-10-CM & ICD-10-PCS

- Annual updates of each system are posted on the ICD-10 website at http://www.cms.gov/ICD10

- Maintenance and updates of ICD-9-CM and ICD-10 are discussed at the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

Tools in Converting Codes

- General Equivalence Mappings (GEMs) assist in converting data from ICD-9-CM to ICD-10

- Forward and backward mappings
  - Information on GEMs and their use – http://www.cms.gov/ICD10 (click on ICD-10-CM or ICD-10-PCS to find most recent GEMs)
  - Description of MS-DRG Conversion Project http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp

Converting Data

- GEMs are not a substitute for learning how to code with ICD-10

- For some small conversion projects it may well be quicker and more accurate to use ICD-10 code books instead of GEMs

Affordable Care Act (ACA)

- Section 10109(c) requires Secretary of HHS to task C&M Committee to obtain input regarding the GEMs
- Make appropriate revisions to GEMs
- Will discuss GEM updates at September 15 C&M meeting http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

Code Updates & Need for a Freeze

- Agenda item for recent ICD-9-CM C&M Committee Meetings
  - Annual code updates make transition planning difficult
  - Vendors, system maintainers, payers, and educators have requested a code freeze
  - Should ICD-10 CM/PCS and/or ICD-9-CM be frozen prior to implementation?
  - When should the freeze begin?

Code Updates & Need for a Freeze

- Summary reports of C&M meetings - http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

- Based on discussions at prior meetings, a limited freeze is being proposed

Code Freeze Proposal

- Last regular, annual updates to both ICD-9-CM and ICD-10 would be made on October 1, 2011
- Only limited ICD-9-CM & ICD-10 updates for new technologies and diseases on October 1, 2012 and for ICD-10 on October 1, 2013
- Regular updates to ICD-10 beginning October 1, 2014

Code Freeze Proposal

- A final decision on any code freeze will be announced at the September 15-16, 2010 ICD-9-CM C&M Committee meeting

- Information on meetings http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp
  - Conference call lines will be provided
  - Audio and written transcripts of meeting will be posted

CMS Resources

- ICD-10 General Information
  http://www.cms.gov/ICD10
- MS-DRG Conversion Report
  http://www.cms.gov/ICD10/Downloads/MsdrgConversion.pdf
- Central Version 5010 and D.0 web page on the CMS website http://www.cms.gov/Versions5010andD0/

CMS ICD-10 Website

- The CMS ICD-10 website http://www.cms.gov/icd10/ provides the latest ICD-10 information and links to resources for providers to prepare for ICD-10 implementation in a 5010 environment.

- CMS Sponsored Calls web page provides current information on CMS national provider conference calls focused on the implementation of ICD-10 http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage. You will find copies of call materials (presentations, written and audio transcripts, etc.).

CMS ICD-10 Website

- Medicare Fee-for-Service Provider Resources http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp#TopOfPage and

- Provider Resources (for all providers) http://www.cms.gov/ICD10/05a_ProviderResources.asp#TopOfPage web pages provide links to a variety of related educational resources and information

CMS ICD-10 Website

- Other information found on the ICD-10 website includes:
  - ICD-10 and 5010 compliance timelines
  - CMS implementation planning
  - Medicaid, payer, and vendor resources
  - Statute and regulations
  - ICD-9-CM Coordination and Maintenance Committee Meetings
  - ICD-10 MS-DRG Conversion Project

Additional Resources

- The following organizations offer providers and others ICD-10 resources
  - WEDI (Workgroup for Electronic Data Interchange)

    http://www.wedi.org

  - HIMSS (Health Information and Management Systems Society)

    http://www.himss.org/icd10

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ICD-10-CM Structure

ICD-9-CM

- 3 - 5 characters
- First character is numeric or alpha (E or V)
- Characters 2- 5 are numeric
- Always at least 3 characters
- Use of decimal after 3 characters

ICD-10-CM

- 3 - 7 characters
- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric
- Characters 3 - 7 are alpha or numeric
- Use of decimal after 3 characters
- Use of dummy placeholder "x"
- Alpha characters are not case-sensitive

ICD-10-CM: Similarities to ICD-9-CM

- Format
  - Tabular List and Index
    - Chapters in Tabular structured similarly to ICD-9-CM, with minor exceptions
      - A few chapters have been restructured
      - Sense organs (eye and ear) separated from Nervous System chapter and moved to their own chapters
    - Index structured the same as ICD-9-CM
      - Alphabetic Index of Diseases and Injuries
      - Alphabetic Index of External Causes
      - Table of Neoplasms
      - Table of Drugs and Chemicals

ICD-10-CM: Similarities to ICD-9-CM

- Many conventions have same meaning
  - Abbreviations, punctuation, symbols, notes such as "code first" and "use additional code"
- Nonspecific codes ("unspecified" or "not otherwise specified") are available to use when detailed documentation to support more specific code is not available

ICD-10-CM: Similarities to ICD-9-CM

- *ICD-10-CM Official Guidelines for Coding and Reporting* accompany and complement ICD-10-CM conventions and instructions
- Adherence to the official coding guidelines in all healthcare settings is required under the Health Insurance Portability and Accountability Act

ICD-10-CM: Differences from ICD-9-CM

- Laterality (side of the body affected) has been added to relevant codes
- Specificity and detail have been greatly expanded
- Expanded codes (e.g., injuries, diabetes, postoperative complications, alcohol/substance abuse)
- Expanded use of combination codes
- Injuries grouped by anatomical site rather than type of injury

ICD-10-CM: Differences from ICD-9-CM

- Added clinical concepts (e.g., underdosing, blood type, coma scale)
- Obstetric codes identify trimester instead of episode of care
- Changes in code definitions (e.g., definition of acute myocardial infarction has changed from 8 to 4 weeks)
- Category restructuring and code reorganization in some chapters
- Codes reflect modern medicine and updated medical terminology

ICD-10-CM: Differences from ICD-9-CM

- Addition of 7th character
  - Used in certain chapters to provide additional information about the encounter
  - Must always be used in the 7th character position
  - If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid

ICD-10-CM: Placeholder "X"

- Addition of dummy placeholder "X" is used in certain codes to:
  - Allow for future expansion
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
- When placeholder character applies, it must be used in order for the code to be considered valid

ICD-10-CM: Excludes Notes

- Excludes1 note
  - Indicates that code identified in the note and code where the note appears cannot be reported together because the 2 conditions cannot occur together

    Example:

    E10 Type 1 Diabetes mellitus

    Excludes1: diabetes mellitus due to underlying condition (E08.-)

    drug or chemical induced diabetes mellitus (E09.-)

    gestational diabetes (O24.4-)
    hyperglycemia NOS (R73.9)

    neonatal diabetes mellitus (P70.2)

    type 2 diabetes mellitus (E11.-)

ICD-10-CM: Excludes Notes

- Excludes2 note
  - Indicates that condition identified in the note is not part of the condition represented by the code where the note appears, so both codes may be reported together if the patient has both conditions

    Example:

    L89 Pressure ulcer

    Excludes2: diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)

    non-pressure chronic ulcer of skin (L97.-)

    skin infections (L00-L08)

    varicose ulcer (I83.0, I83.2)

ICD-10-CM Coding Examples

Type I diabetes mellitus with diabetic nephropathy

Step 1

Look up term in Alphabetic Index:

Diabetes, diabetic (mellitus) (sugar) E11.9

type 1 E10.9

with

nephropathy E10.21

ICD-10-CM Coding Examples

Type I diabetes mellitus with diabetic nephropathy (con't)

Step 2

Verify code in Tabular:

E10 Type 1 diabetes mellitus

E10.2 Type 1 diabetes mellitus with kidney complications

E10.21 Type 1 diabetes mellitus with diabetic nephropathy

Type 1 diabetes mellitus with intercapillary glomerulosclerosis

Type 1 diabetes mellitus with intracapillary glomerulonephrosis

Type 1 diabetes mellitus with Kimmelstiel-Wilson disease

ICD-10-PCS – Structure

ICD-9-CM

- ICD-9-CM has 3-4 characters
- All characters are numeric
- All codes have at least 3 characters
- Alpha characters are not case-sensitive
- Decimal after 2nd character

ICD-10-PCS

- ICD-10-PCS has 7 characters
- Each can be either alpha or numeric
- Numbers 0-9; letters A-H, J-N, P-Z
- Alpha characters are not case-sensitive
- Each code must have 7 characters
- No decimal

ICD-10-PCS Code Example

Trigeminal to facial nerve transfer, percutaneous endoscopic

Code: 00XK4ZM

0 = Medical and Surgical (section)

0 = Central Nervous System (body system)

X = Transfer (root operation)

K = Trigeminal Nerve (body part)

4 = Percutaneous Endoscopic (approach)

Z = None (device)

M = Facial Nerve (qualifier)

AHIMA Resources

http://www.ahima.org/icd10

- Practical guidance **(free)**
  - *Putting the ICD-10-CM/ PCS GEMs into Practice*
  - *ICD-10 Preparation Checklist*
  - Role-based implementation models
  - ICD-10 Readiness and Prioritization Tool
- Books
  - *Pocket Guide of ICD-10-CM and ICD-10-PCS*
  - *ICD-10-CM and ICD-10-PCS Preview*
- Online courses
  - ICD-10-CM and ICD-10-PCS overview courses
  - Fundamentals of GEMs course
- Proficiency assessments
- Academy for ICD-10 Trainers
  - Academy for ICD-10-CM/PCS (3 days)
  - Academy for ICD-10-CM only (1 ½ days)
- E-newsletter **(free)**
- Articles **(many are free)**
- Webinars/Conferences

Medicare Fee-For-Service (FFS) Implementation of HIPAA 5010 and D.0

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Purpose

- Review compliance dates and timelines
- Describe requirements for 5010 implementation
- Conduct a readiness review for implementing HIPAA version 5010 and D.0
- Review what you need to be doing to prepare
- Provide Medicare FFS activities update
- Share other issues and considerations

5010 General Overview

What was adopted under the HIPAA Modifications Rule?

- Version 5010 of the X12 standards suite of administrative transactions
- Version D.0 of the National Council for Prescription Drug Program (NCPDP) suite for retail pharmacy
  - Version D.0 or Version 5010 for retail pharmacy supplies and services, based on trading partner agreements

Who is impacted?

- HIPAA covered entities (i.e., providers, health plans, clearinghouses) and their business associates (i.e., billing/service agents)

Medicare FFS 5010 Program

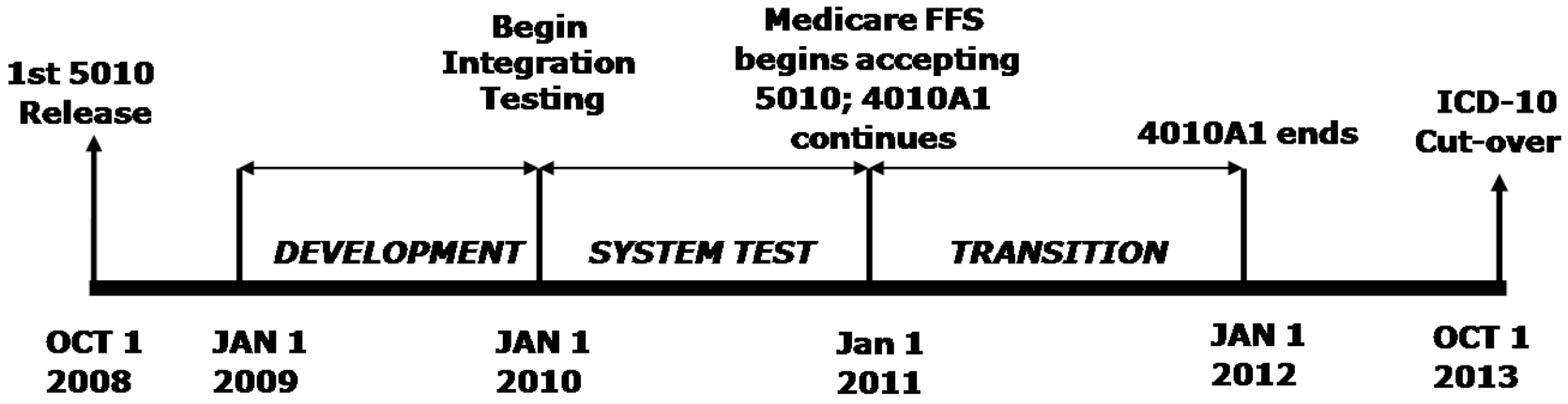
- HIPAA legislation mandates that the healthcare industry use standard formats for electronic claims and related transactions
  - The Medicare FFS "HIPAA 5010" program implements new versions of these transaction standards (ASC X12 Version 5010 and NCPDP Version D.0)
- The HIPAA 5010 program also implements:
  - "Infrastructure" preparation for ICD-10
    - Version 5010 accommodates ICD-10 CM & PCS code sets and Version 4010A1 does not
    - Medicare FFS will begin processing up to 25 diagnosis and 25 procedure codes per electronic claim
  - New ASC X12 standard acknowledgement and rejection transactions
    - The Functional Acknowledgement 999 replaces the 997 transaction
    - The Claims Acknowledgement (277CA) will be used to replace proprietary error reporting
  - Selected system and process enhancements that move Medicare FFS processing towards modernization

Medicare FFS Compliance Dates and Timelines

Compliance Dates for 5010 and D.0:

- Mandatory compliance on January 1, 2012 – all covered entities
  - Internal Testing to begin on or after January 1, 2010
  - External testing to begin on or after January 1, 2011

Timeline:



5010 Requirements for Implementation

- Test new formats. Medicare will be ready to support test-to-production January 1, 2011
- After 5010 Implementation concludes on January 1, 2012, all covered entities are required to:
  - Submit and be able to receive compliant HIPAA version 5010 electronic transactions (837 I, 837 P, 837 COB, 270/271, 276,277, 277CA, 999, TA1)
  - Although the 5010 format allows ICD-9 and/or ICD-10 CM & PCS code set values in the transaction standard, until ICD-10 compliance date, continue to submit ICD-9 codes on all claims
- After ICD-10 Implementation on October 1, 2013, all covered entities are required to:
  - Submit ICD-10 codes on professional claims with a date of service or institutional claims with a discharge date, of October 1, 2013 or later
    - Medicare FFS will allow processing of claims with ICD-9 codes beyond October 1, 2013 for a period of time, for claims with dates of service or discharge dates prior to October 1, 2013, to allow billing cycles to catch up

5010 Readiness Review

Have you….

1. Contacted your system vendors and asked the following questions?
   a) Does your license include regulation updates?
   b) Will the upgrade include acknowledgement transactions 277CA & 999?
   c) Will the upgrade include a "readable" error report produced from these 277CA and 999 transactions?

2. Inquired when your vendor is planning to upgrade your system?
   a) Assess this response to be sure your vendor can assure your transition well before the cutoff, Jan 1 2012
   b) Be wary if your vendor is planning to upgrade late in 2011 and encourage them to do it sooner – the Medicare Administrative Contractors (MACs) may not be able to handle a flood of requests to test and certify the systems are ready for production late in 2011 for an implementation deadline of January 1, 2012

3. Evaluated the impact to your routine operations and began planning for training, transition?
   a) Contact your local MAC to get more information on how to proceed with training and transition

5010: What You Need to Do to Prepare

General Resources

- To purchase Implementation Guides and access Technical Questions
  - X12: http://www.x12.org
  - X12 portal: http://store.x12.org
  - NCPDP (for D.0 and 3.0): http://www.ncpdp.org
- To view X12 Responses to Technical Comments
  - http://www.cms.gov/TransactionCodeSetsStands/
- Other
  - To request changes to standards: http://www.hipaa-dsmo.org
  - CMS website for industry wide information: http://www.cms.gov

5010: What You Need to Do to Prepare

Know What Must Be Changed

- The formats currently used must be upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0
- Systems that submit claims, receive remittances, exchange claim status or eligibility inquiry and responses must be analyzed to identify software and business process changes
- The new versions have different data element requirements
- Medicare FFS has performed a comparison of the current and new formats for the transactions used and they can be found at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
- Software must be modified to produce and exchange the new formats
- Business processes may need to be changed to capture additional data elements now required
- Transition to the new formats must be coordinated:
  - Continue to use the current formats for some Trading Partners' exchange
  - Start to use the new formats with other Trading Partners

5010: What You Need to Do to Prepare

Know What Resources are Available to You for Medicare FFS

- CMS has developed educational materials on the Medicare Fee-for-Service 5010 program to provide technical assistance and direction for our trading partners and providers

- Products include:
  - Central Version 5010 and D.0 Webpage on the CMS website http://www.cms.gov/Versions5010andD0/
    - Educational Resources (MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
    - Dedicated HIPAA 5010/D.0 Project web page (technical documents and communications at national conferences) http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
  - Update Announcements and News Flashes – to subscribe to CMS list serves go to http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf

5010: What You Need to Do to Prepare

Know What Resources are Available to You for Medicare FFS (continued)

- National Provider Calls Specific to Medicare FFS Implementation of HIPAA version 5010*
  - 6/9/09 General Overview
  - 8/26/09 Error Handling Transactions (TA1, 999, and 277CA) For Clearinghouses and Billing Software Vendors
  - 9/9/09 Error Handling Transactions (TA1, 999, and 277CA) For Clearinghouses and Billing Software Vendors
  - 3/24/10 General Overview and Error Handling Transactions (TA1, 999, and 277CA) for Providers, Clearinghouses and Billing Software Vendors
  - 4/28/10 270/271 Eligibility Request/Response
  - 5/26/10 837 Professional Claim
  - 6/30/10 837 Institutional Claim
  - 7/28/10 276/277 Claim Status Request/Response
  - 8/25/10 835 Remittance Advice
  - 9/29/10 TA1, 999, 277CA Acknowledgments
  - 10/27/10 NCPDP Version D.0
  - 12/8/10 MAC Preparation and Outreach on their 5010/D.0 Implementations

*To obtain copies of the presentations, transcripts and recordings of previous calls, go to: http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage .

Medicare FFS 5010 Implementation Activities Update

- A Certification Test Phase for Medicare Front End systems is planned for October through December 2010
- Medicare Administrative Contractors (MACs) are preparing to test with providers starting January 1, 2011
  - Providers interested in testing their 5010 transactions should contact their MAC, Fiscal Intermediary (FI) or Carrier for more information
- Medicare FFS will be sponsoring more Outreach and Education throughout the 2011 transition year

Other Issues and Considerations
ASC X12 Errata

- X12 5010 Errata was identified for 834, 835, 837I, 837P, 270/271 and 999
- Type 1 Errata means significant changes made and the value in GS08 changes (e.g. 05010X222E2)
- Type 2 Errata means non-significant changes made and no changes required for trading partners to exchange transactions (i.e. errors are *typographical* in nature)
- You are encouraged to review the audiocast materials for a complete discussion on the scope of change to Medicare FFS caused by each transaction's errata

Other Issues and Considerations
ASC X12 Errata

- CMS collected errata comments from the MACs and Shared Systems and submitted a response to ASC X12 on the errata. There is minimal impact to the Medicare FFS program

- CMS will address the errata as a Shared System maintenance work item in the Fee-For Service program as a Change Request (CR)

- Routine scheduling of Change Requests for quarterly releases requires 8 months lead time

- Pending the publication of the Interim Final Rule and scheduling the necessary Change Requests, Medicare FFS will use the current published Technical Report 3 (TR3) versions

What Happens if Providers Do Not Transition?

- Providers who are not ready to submit electronic 5010 or D.0 transactions on January 1, 2011 to Medicare FFS will continue to be permitted to submit electronic 4010A1 or 5.1 transactions.

- Providers who are not ready to submit electronic 5010 or D.0 transactions by January 1, 2012 can expect to have their claims rejected. Medicare FFS will only accept claims in version 5010 or D.0 at that time.

- Providers who are eligible to submit paper claims (Institutional and Professional) will not experience a change in the paper claim form for 5010 or ICD-10 projects

National Provider Conference Call Continuing Education Information

Continuing Education Information

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS National Provider Conference Calls.

- American Academy of Professional Coders (AAPC)
  If you have attended or are planning to attend one of CMS' National Provider Conference Calls, you should be aware that CMS does not provide certificates of attendance for these calls. Instead, the AAPC will accept your e-mailed confirmation and call description as proof of participation. Please retain a copy of your e-mailed confirmation for these calls as the AAPC will request them for any conference call you entered into your CEU Tracker if you are chosen for CEU verification. Members are awarded one (1) CEU per hour of participation.

Continuing Education Information

- American Health Information Management Association (AHIMA)

  AHIMA credential-holders may claim 1 CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA, nor does a CEU certificate need to be provided, in order to claim AHIMA CEU credit. For detailed information about AHIMA's CEU requirements, see the Recertification Guide on AHIMA's web site.

Please note: The statements above are standard language provided to CMS by the AAPC and the AHIMA. If you have any questions concerning either statement, please contact the respective organization, not CMS.

Questions?