

Effective Data, Inc.
White Paper:

ICD9 to ICD10
X12 4010 to 5010
Conversion Impact



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Introduction

Currently the ICD-9-CM is used for diagnosis coding in most inpatient and outpatient settings. The use of ICD-10 codes for medical diagnosis and procedure coding has been debated for a number of years and if fact has been in use outside of the United States for over 10 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.

At Effective Data, we specialize in EDI Consulting and Data Integration. Founded by EDI experts, ED has been a pioneer in the electronic commerce consulting arena since 1991. Effective Data's core competency is developing and managing technically robust B2B Solutions. With each project, our Specialists collaborate to identify key business objectives, define a solution, and continually manage the project through implementation with a thorough understanding of industry standards, best practices and technology.

Executive Summary

The United States Healthcare system has endeavored to give providers a systematic way to classify diseases in order to standardize the way the providers bill for services and ensure accuracy of payments by insurance companies. Most of the world's developed healthcare systems follow the World Health Organization (WHO) International Classification of Diseases (ICD). This coding scheme is used to classify morbidity and mortality data for vital statistics tracking and for health insurance claim reimbursement.

Since its inception, the ICD has undergone a number of iterations. The United States Government mandated the move from the ICD-9 system to an expanded ICD-10 version to be implemented by October 1, 2013. This is a far more complex scheme reflecting changes in disease detection and treatment regimens.

In addition, the government has also mandated an upgrade of the nine HIPAA transaction formats for electronic data transmission from the initial 4010 version to version 5010. The deadline for this implementation is January 1, 2012 to accommodate the expanded ICD-10 codes.

These changes require a massive overhaul of the nation's medical coding system because ICD-9 codes are deeply embedded as part of the coding, reporting, and reimbursement methodology in use today.

In order to develop an effective consecutive implementation for these two major changes will require strategic planning to include training, interaction with vendor systems, changes to internal legacy systems, benefit and provider contractual changes, and testing to ensure a transparent changeover.

All of this must be completed while maintaining business as usual. Further, these are unfunded mandates that require healthcare stakeholders to provide significant resources and funding themselves.

This paper provides an understanding of the HIPAA and ICD code sets as well as the benefits to be derived and the critical success factors that must be met in order to successfully complete these complex transitions.

Statement of Problem

Adoption of the ICD-10 Code Sets has become a question of when, not if, yet there is still trepidation within the health industry. This reluctance stems from concern on the part of some within the health care industry, particularly payors. There seems to be a lack of 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.

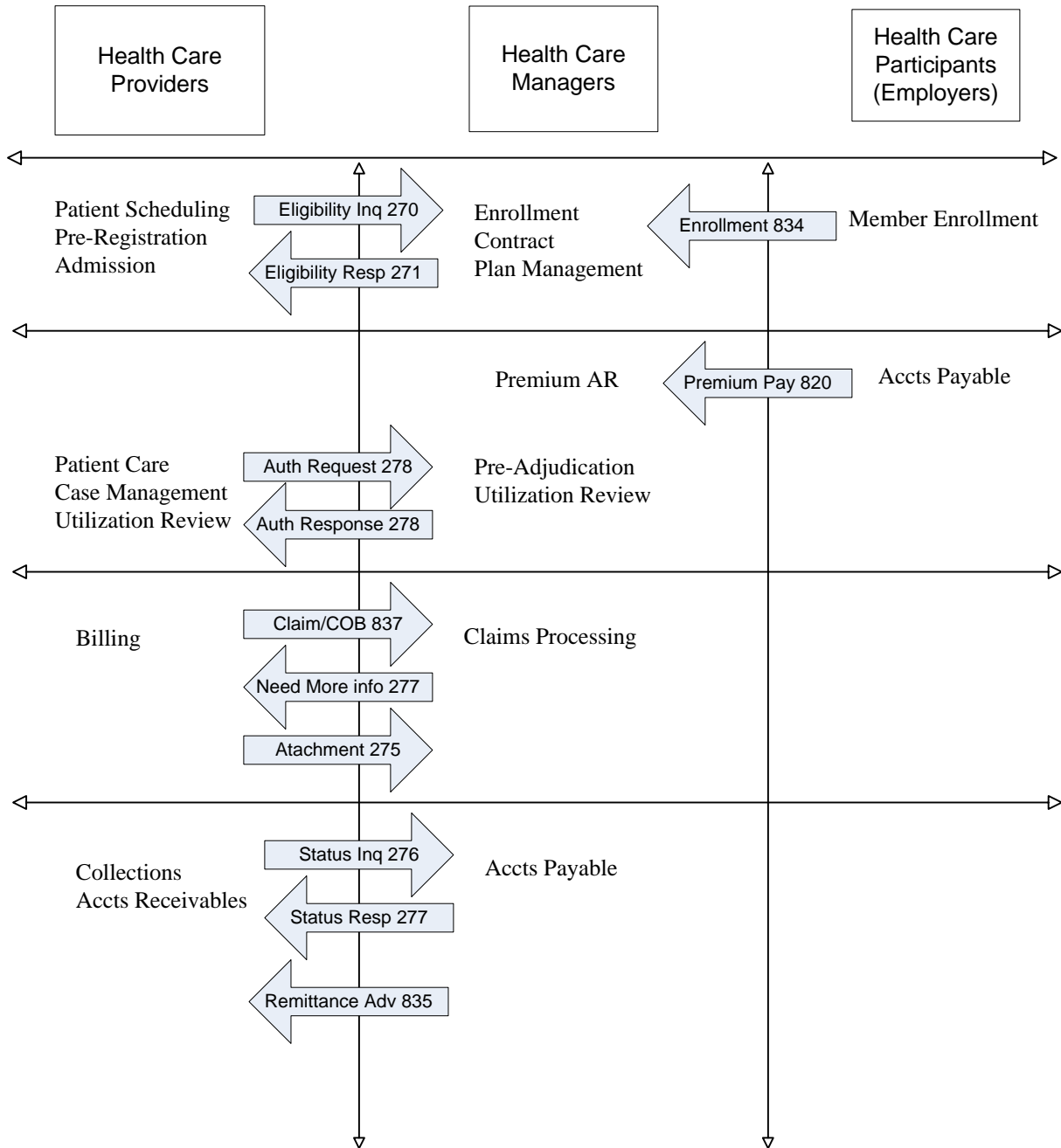
To complicate life (or to make it more interesting) there is no such thing as a 1-to-1 mapping between ICD-9 and ICD-10; ICD-10 is not just a superset of ICD-9; it's a totally different code set. There are cases in which an ICD-9 code has a precise match in ICD-10, but in most cases that's not true; in some cases there are only approximate matches available; in some others multiple possible matches exist; in some others only combinations of multiple ICD-10 codes can replace the information conveyed in a single ICD-9 code. Speaking of HIPAA, multiple versions, conversions and mappings, the question is inevitable: is there anything that the data integration technology can do to help?

To answer that question you must start looking for more details and a lot of information is available on HHS.gov. You can find and download [text files containing the full description](#) of the ICD-9 and ICD-10 diagnostic codes, and the "set of general equivalence mappings". The mappings file is a bit cryptic to read, but it does contain all the details about exact/approximate/multiple-choice matches between ICD-9 and ICD-10 diagnostic codes.

The 5010 Version is massive and includes more than 850 complex changes. For example, the changes to the Healthcare claim, transaction 837, include 700 pages of instructions with a change on every page. This HIPAA format conversion must be completed by January 1, 2012, in advance of the ICD-10 implementation in order to accommodate the extended diagnosis/procedure codes. It is also critical that during the 5010 conversion, payers and providers operate dual processing systems – one to process live claims with 4010 formats and a second to process 5010 transactions for testing and analytics.

What is the 4010 to 5010 conversion and what does it involve?

Version 4010 was adopted on August 17, 2000 and included standardization of 9 formats for electronic data transmissions (paper transactions are excluded at present). They included:



Summary of Impact

Why upgrade to version 5010 / ICD-10:

- Current transactions are over 6 years old
 - More than 500 industry requested changes via DSMO (Designated Standards Maintenance Organizations)
 - Many more industry requested changes via ASC X12
- Addresses problems encountered with 4010A1
- Improvements to implementation instructions
 - More consistent implementations by trading partners
 - Some problems prevented implementation
 - Should reduce Companion Guide Trading Partner requirements
- Upgrade: not HIPPA part II:
- Change analysis will require a thorough review of all transaction Implementation Guides (IG's)
- Analysis is X12 to X12
 - Less complicated than with round 1
- Changes are not a 100% change
 - Some transactions changed very little
 - Other transactions changed moderately
 - Others had significant changes (claims)

Summary of Changes

- More standardized front matter
- Addressed industry needs missing from 4010
- Clarified intent where previously ambiguous
- Improved instructions for business situations that were causing problems in 4010
 - In particular, privacy issues were addressed
- Added or Deleted code values and qualifiers:
 - To address industry requests
 - To reduce confusion from similar or redundant values

270/271 Eligibility

- Clarified instructions for sending inquiries:
 - When subscriber is patient
 - When dependent is patient
- Newly required response information
 - When a patient has active benefit coverage, the health plan must report:
 - Beginning effective eligibility date, Plan name, and the Benefit effective dates if different from the overall coverage.
 - All demographic information needed by the health plan on subsequent transactions must be reported, primary care provider if available, and other payers if known.
- Required alternate search options
 - When payers are unable to find member eligibility information using all the data elements of the primary search, health plans must support inquiries with:
 - Member ID, Last name only, and Date of Birth to help eliminate false negatives.
 - This was a controversial requirement, and was just modified during the June trimester meeting, changes to the TR3 (Implementation Guide) will be forthcoming to reflect this modification.
- Clear requirements for reporting patient responsibility with a monetary amount or percentage
- Added 38 new service type codes
- Clarified patient financial responsibility information

Claims

- Fixed significant industry problems:
 - Improved front matter explanation of COB reporting and balancing logic
 - Section added to explain allowed and approved amounts – reporting calculations
 - Added COB crosswalk – and examples
 - Subscriber/patient hierarchy modified
 - If patient has a unique identifier, then patient is considered to be the subscriber (same as eligibility)
 - 837I Provider types were redefined in conjunction with the NUBC code set
 - Improved rules and instructions for reporting provider roles and use of NPI
 - NPI and proprietary identifiers will still be supported for atypical providers
 - Added front matter sections to:
 - Explain Medicaid subrogation, Pay-to Plan information
 - Explain reporting of drug claims
 - 837I Multi-functional segments for provider and diagnosis types are separated to allow:
 - Referring, Rendering, and Other Operating replace “Other provider”
 - Multiple reasons for visit and external causes of injury allowed on same claim
 - Separate element added for tax number

Claims New Functions

- Added support for ICD-10
- Present on Admission indicator – (837I)
- Ambulance pick-up and drop-off locations
- Remaining patient liability (clarifies COB – 837I & P)
- National health plan ID (to support when identifier is adopted)
- Repricer designated as transaction destination

Claims Deleted Functions

- Items deleted to eliminate duplicated functions or functions handled in another by the industry
- Responsible party
- Credit/debit card holder
- Home health
- Purchased service provider
- Referring provider specialty

266/267 Claim Status

- Eliminated sensitive patient information that was unnecessary for business purpose
- Added Pharmacy related data segments and the use of NCPDP Payment Reject Codes
- Increased Claim Status segment repeat to > 1 for more detailed status information
- Added more examples to clarify instructions

835 Claims Remittance

- Tighter business rules to eliminate options
- Added another PER segments to loop 1000A
 - Health care medical policy – via payer URL
- Added Remittance Delivery Method (RDM) segment to loop 1000B – payment options
- Claim status has clearer guidance to report how a claim was adjudicated
 - Better instructions for handling reversals and corrections; interest payments and prompt pay discounts
 - Limits use of denial claim status to specific business case
 - Advanced payments and reconciliation
- Secondary payment reporting considerations section revised
- Reporting encounters

Conclusion

The Time to Act Is Now

Reacting to many public comments that earlier proposed deadlines were unworkable, Health and Human Services (HHS) said in January that most healthcare organizations have until January 1, 2012, to meet both the 5010 standards and the associated National Council for Prescription Drug Programs version D.0, which replaces the current version 5.1. The ICD-10 compliance date now is set for October 1, 2013.

The ANSI 5010 ICD-10 standards are ready to go, though HHS always reserves the right to make modifications—with a public comment period—as it did in 2002 with the HIPAA privacy standards. Still, the extra time should not allow for complacency. The National Committee on Vital and Health Statistics, an HHS advisory board, recommends allowing two years to build and install new systems, plus additional time for testing. The Workgroup for Electronic Data Interchange says testing should take a minimum of one year.

Get in touch with health plans, technology vendors, clearinghouses, and other business associates as soon as possible and ask when they expect to accept test claims under the 5010 standard. There is no reason to wait.

Contact Effective Data now to get started on your ICD-10 Initiatives.

About Us

Effective Data builds and maintains long-term business relationships with our clients. Offering a unique approach to each project and unsurpassed responsiveness, our clients receive EDI services that are aligned to meet their specific technology needs and business objectives. Before you move ahead with your next project, evaluate our past. Clients include:

Company names and/or trademarks are the properties of their respective companies

Further details and testimonials from our client base can be obtained by contacting our offices, or visiting us on the web at www.effective-data.com.