

Implementing HIPAA 2 – New Transactions, New Code Sets; What Does it Really Take?

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On January 16, 2009 the Department of Health and Human Services (HHS) published 2 Final Rules establishing the next set of HIPAA standards. The first rule adopted upgraded X12 and NCPDP versions for administrative transactions (claims, eligibility inquiries, remittance advices, etc.). This rule required compliance with the new versions by January 1, 2012. The new X12 version is 5010, the new NCPDP version is D.0. The second rule adopted the ICD-10 code sets for diagnoses and inpatient hospital procedure coding. The ICD-10 code sets (ICD-10-CM for diagnoses, ICD-10-PCS for inpatient hospital procedures) must be used on transactions for services provided on and after Oct 1, 2013. Note the difference in implementation requirements. The transactions are implemented based on date of transaction, the code sets are implemented based on date of service.

Transaction Standard Upgrades

The rule for upgrading the transaction standards had an interesting wrinkle in it. The rule allowed the new transaction standards to be used prior to the compliance date of January 1, 2012 if trading partners agreed. This allows a spreading out of the testing and transition period if trading partners are willing to move to the new standard earlier than the compliance date.

The new versions of the standards bring considerable improvements to the business processes that they support. The standards organizations (X12 and NCPDP) have worked diligently to bring more clarity and consistency to the instructions for use of the transactions, and to support some of the newer business needs. Medicare Part D requirements are included in the new NCPDP pharmacy transactions. ICD-10 codes are supported in all transactions. There is much more uniformity in the “situational” rules in the transactions. This should minimize differences in usage among health plans, reducing the need for companion guides.

The new claims transactions include several changes for more accurate reporting. The institutional claim enables the use of the “Present on Admission” diagnosis indicator. It also provides more clarity on reporting various types of diagnoses (admitting, treatment, etc.). The claim instructions clarify use of the NPI – they require that the NPI reported for the billing provider be at the most granular level of enumeration for the provider, and be used consistently for all health plans. Requirements for reporting anesthesia services have changed. Anesthesia services must now be reported in minutes, as opposed to the previous options of units or minutes.

The remittance advice implementation guide has clarified many items, especially those in regard to producing a balanced remittance advice. It also includes a medical policy segment to allow plan to report medical policy reasons for adjusting payments. Interestingly, the new version (5010) of the remittance advice can be used to respond to the earlier version (4010) of claims. Health plans could take advantage of the improved transaction well before the compliance date, even if providers are sending in the earlier version of the claim.

The eligibility inquiry and response transactions have added required reporting for specific benefit categories and service types. Plans are now required to provide eligibility information on specific services (e.g hospital) when responding to inquiries, in addition to the simple yes or no eligibility response. The X12 organization has also clarified the meaning of subscriber and dependent. Any individual that has a unique ID number is considered a subscriber and must be reported as such on eligibility inquiries and claims. That number is considered unique even if it only differs from other family members by the use of a suffix.

The claims status inquiry and response transaction has been modified to allow prescription number reporting. Sensitive information has been eliminated from the transaction to satisfy concerns raised about privacy. The implementation guide has specific instruction for both batch and real time use.

The coordination of benefits transaction instructions have been rewritten to eliminate many of the ambiguities which existed in the previous guide.

The prior authorization and referral transaction has been transformed to provide a transaction which meets industry business needs. It provides for specific information on a patient’s condition, allows for information on the number of occurrences of a service, and allows for better reporting of multiple conditions. This should allow for significantly increased support and use of this electronic transaction

The enrollment and premium payment transactions (primarily used between sponsors/employers and health plans) have been revised to include more functions needed by users.

So, in general, the new versions provide more information and better support current business practices. This should enable providers and health plans to automate more business functions to improve productivity and use staff for other types of work. It is expected that there will be significant increases in the use of the electronic eligibility and remittance advice transactions in particular. We should see an increase in the number of health plans supporting real time transactions.

What Should Providers Do?

It is imperative that providers understand the changes in the transactions and what they can mean for your organization. This is not only an information technology effort, it is a business process change effort. While your vendors may provide the software upgrades, providers must make the necessary business changes to take advantage of these new transactions. Providers must contact their vendors, clearinghouses, and health plans to determine when they will be moving to the 5010 standards, and make sure that their vendors will provide timely updates. A complete workplan for implementing these changes should be established and tracked to assure that the compliance date is met. CMS/Medicare has announced that they will be ready on Jan 1, 2012 and that there will be no extensions granted.

ICD-10 Upgrade

So What Is the Big Deal with ICD-10?

The second of the two new HIPAA requirements is the upgrading of the code sets for diagnoses and inpatient hospital procedures. Coding is required to move to ICD-10 from ICD-9 for services delivered on and after Oct 1, 2013. Why is this such a major effort? Codes usually change on an annual basis anyway every Oct 1. All of the transactions will be revised to accommodate the new code sets. This appears to be just business as usual.

However it is not. The change from ICD-9 to ICD-10 is a major change to the code sets, far beyond the annual changes that have been done. ICD-10 is markedly different from ICD-9, both in structure and in meaning. The code set change will require changes to almost all business processes and clinical and administrative systems in providers and health plans, including changes in reimbursement and coverage determinations.

Let's look at some of the changes in the code sets. The diagnosis code set is changing from ICD-9-CM to ICD-10-CM. The ICD-10-CM codes can be up to 7 positions, the ICD-9 codes were up to 5 positions. The "10" codes contain both letters and numbers in all positions, the "9" codes had only the first position with letters and numbers, the rest were only numbers. There will be over 68,000 diagnosis codes to deal with in ICD-10. ICD-9 had around 13,000.

More importantly, ICD-10 codes provide much greater specificity in the diagnoses. A few examples are helpful here.

- Diabetes mellitus codes are expanded to include the classification of the diabetes and the manifestation. The category for diabetes mellitus has been updated to reflect the current clinical classification of diabetes and is no longer classified as controlled/uncontrolled:
 - E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
 - E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
 - E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
 - E11.41, Type 2 diabetes mellitus with diabetic mononeuropathy

- Hematuria codes are much more specific

- ICD-9-CM 599.7 Hematuria (blood in urine)

- ICD-10-CM
 - R31.0 Gross hematuria
 - R31.1 Benign essential microscopic hematuria
 - R31.2 Other microscopic hematuria
 - R31.9 Hematuria, unspecified

- Sports injuries now coded with sport and reason for injury –
 - ICD-9 code - **Striking against or struck accidentally in sports without subsequent fall (E917.0)**
 - **24 ICD-10-CM Detail Codes**
 - W21.00 Struck by hit or thrown ball, unspecified type
 - W21.01 Struck by football
 - W21.02 Struck by soccer ball
 - W21.03 Struck by baseball
 - W21.04 Struck by golf ball
 - W21.05 Struck by basketball
 - W21.06 Struck by volleyball
 - W21.07 Struck by softball
 - W21.09 Struck by other hit or thrown ball
 - W21.31 Struck by shoe cleats
 - Stepped on by shoe cleats
 - W21.32 Struck by skate blades
 - Skated over by skate blades
 - W21.39 Struck by other sports
 - foot wear
 - W21.4 Striking against diving board

There were also some structural changes and additional functionalities added to the code set. ICD-10 codes contain diagnoses for right and left sides (e.g. right arm vs. left arm). The obstetric diagnosis section was rewritten. In ICD-9-CM, the patient is classified by diagnosis in relation to the episode of care. In ICD-10-CM the patient is classified by diagnosis in relation to the patient's stage of pregnancy. Disease severity is also included in many diagnoses. For example, asthma diagnoses include the reporting of mild, moderate, and severe asthma.

The procedure code set has been completely rewritten in ICD-10-PCS. While the diagnosis codes use the generic ICD-10 code set developed by the World Health Organization, the procedure codes are an independent US creation, not used anywhere else in the world. The 10-PCS code set also includes 7 positions, with each position having a specific meaning. Remember that this code set is only used to code inpatient hospital procedures, but physician staff will need to be familiar with the code set to assure appropriate documentation.

The positions of the code set have specific meaning. Position 1 is the section of the code set, position 2 is the body system, position 3 is the root operation taking place, position 4 is the body part, position 5 is the approach, position 6 refers to a device, and position 7 is a qualifier.

Here is an example of the PCS code.

- ICD-9-CM (sample code)
 - 47.01 Laparoscopic appendectomy
- ICD-10-PCS (sample code)
- Laparoscopic appendectomy ODTJ4ZZ
 - 0 - Medical and Surgical Section
 - D - Gastrointestinal system
 - T - Resection (root operation)
 - J - Appendix (body part)
 - 4 - Percutaneous endoscopic (approach)
 - Z - No device
 - Z - No qualifier

Why are the code sets being upgraded now? Firstly, the ICD-9 code sets are over 25 years old, with outdated terminology. There is a need to provide increased information for public health, biosurveillance, and quality measurement. And the ICD-9 code set is simply running out of space for new codes.

However, there is a key implementation issue that is making this transition quite difficult. Because of change in the code set structure, organization, and meaning, there is no clear mapping from the ICD-9 to the ICD-10 code sets. If it were only about specificity, one would think that each ICD-9 code would be broken down into several ICD-10 codes, allowing for an easy translation. But this is not the case. Some codes map 1-1, some ICD-9 codes do not map to any ICD-10 codes, and there are many “approximate” maps, not exact translations. In some situations, it takes two or more ICD-9 codes to express one ICD-10 code. There is some guidance available, with CMS publishing General Equivalence Maps, (the GEM files) which show these relationships. The GEMs are good as a learning and comparison tool, but cannot be used exclusively to create the 1-1 mappings which may be desired.

So without unambiguous maps from one code set to the next, there will need to be an analysis of all of the rules and processes which use diagnosis codes to determine the impact. And that is virtually every process in a provider and health plan. For providers, this ranges from determining patients insurance coverage thru documentation and billing. Because of expected changes in coverage and reimbursement methods using these new diagnosis and procedure codes, significant changes in cash flow can be expected.

Specific provider impacts will include the need for increased specificity in documentation to support the more specific coding. Some studies from the American Association of Professional Coders have shown an increase of 15% in physician documentation time. It is expected that during the first year or so using ICD-10, there will be an increase in denials and requests for additional documentation as both providers and health plans learn to use the new code set.

Health plans will be revising their coverage and medical review policies based on the new codes. Provider offices will have to learn about these changes, and may have to explain these changes to patients if coverage or reimbursement is impacted. Health plan contracts will need to be renegotiated if diagnosis codes are included. A major difficulty with this will be the problem in predicting what a provider’s ICD-10 based caseload will look like, since the codes will not be used until after the contracts are signed.

Quality and pay for performance measures often use diagnosis codes. These will need to be rewritten based on the new ICD-10 codes.

This change in codes will also have a significant impact on almost all business operations of health plans. Because diagnosis and inpatient hospital codes are used throughout the health plan, significant changes can be expected in their coverage and reimbursement policies and procedures, medical review policies, benefit structures, statistical reporting, fraud and abuse monitoring, actuarial projections, case management , and quality reporting.

What are the expected implementation steps for providers? Training is a key area, as not only coders need to be trained. Administrative and system staff will need to understand the code set changes, how they impact the organization, and what changes need to be made. Then, once changes are made, staff will need to be trained on the business and system changes.

A robust business impact analysis must be conducted to determine the extent of the codes set change impact. Organizations need to determine where diagnoses/inpatient hospital procedure coding is used, what system interfaces may need to be changed, what databases and systems need to be changed, and what policies and procedures need to be changed to support the new codes.

Each organization must determine a workplan to implement the changes in time for the compliance date of Oct 1, 2013, including enough time for testing both internally and with all trading partners. Appropriate budget must be determined and allocated, as well as resources assigned to the necessary tasks. Vendors need to be contacted to determine their ICD-10 implementation schedules. An important consideration is how ICD-10 will impact other major initiatives planned between now and Oct 2013.

One of the major areas for providers to examine will be their documentation requirements. A review should be done of current documentation to determine if it is specific enough to support the more detailed ICD-10 codes. If not, documentation procedures need to be revised and clinicians trained. It may be necessary to move to an automated tool for documentation, especially if current superbills cannot be easily modified for ICD-10.

Once the major business decisions are made, the IT systems must be revised to accommodate the codes and process changes. Given the expected scope of the changes, end-to-end testing of all processes, both internally and with trading partners, is highly recommended to assure that accurate transactions are created and claims are properly submitted and paid with the new ICD-10 codes.

Providers will need to develop communication channels on ICD-10 with vendors, with trading partners, and with patients. The impact of changes in coverage and payment will be something that patients may not understand in the transitions, so providers should determine how best to communicate with them on this topic.

It is difficult to predict costs for providers, but some rough estimates for each part of the project have been developed. ICD-10 training is conservatively estimated at about \$200 per provider and administrative staff, with coders costing around \$1600 for basic online training. The business process review and analysis is expected to take 3-4 months for a team to research. IT costs are expected to be much higher than for implementing HIPAA transactions, as the breadth and scope of the effort is much greater due to the impact on more business areas and processes. And there is a danger of cash flow interruptions during the first few months of the transition, as plans and providers learn to code and process claims in ICD-10. The expected increase in delays and rejection will decrease cash flow by at least 1%.

It is imperative that providers begin the implementation planning immediately, as this projected is estimated to take all of the time until the compliance date. Remember that the HIPAA transaction upgrade process is also occurring. You should have already contacted your vendors to begin your ICD-10 planning. Medicare insists that they will be using ICD-10 at the compliance deadline, so it is critical that providers be ready to use it.

So, key points:

- Understand the impacts, begin the planning process
- Talk to vendors
- Start the budgeting process
- Identify key staff to begin
- Track progress of CMS/Medicare and NCHS efforts.

Additional Information can be found at:

- NCHS – Basic ICD-10-CM information
 - <http://www.cdc.gov/nchs/about/otheract/icd9/abtcd10.htm>
- CMS – ICD-10-PCS information
 - http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp
- AHIMA - ICD-10 Education
 - <http://www.ahima.org/icd10/index.asp>
- WEDI – ICD-10 Implementation
 - www.wedi.org

