

*Published by Milliman, 1301
 Fifth Ave., Suite 3000, Seattle, W.
 health.perspectives.editor@
 milliman.com*

Claims and the transition to ICD-10

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In making the transition to ICD-10, health plans will have to overcome numerous internal and external challenges, including cost, technology resource constraints, and competing priorities. A candid examination of the potential issues brought on by this change is necessary to mitigate risk. Here, we will exemplify the benefits of such an assessment by examining the claim-payment process.

There is no silver bullet

While many organizations perceive code mapping and cross-walks as a solution for claim processing under ICD-10, this approach leaves many issues unresolved and may present a few new ones. Because plans need to utilize crucial historical data while maintaining current operations and because not all systems will be ready to handle ICD-10 at the same time, forward and backward mapping between the two code sets will be necessary over many months, and possibly years. Thus, during the transition to ICD-10, payers may need to translate claims into ICD-9, even if they are paying under the ICD-10 scheme. Furthermore, because it is not a simple one-to-one mapping between ICD-9 and ICD-10, there may be other unexpected consequences.

Expect delays

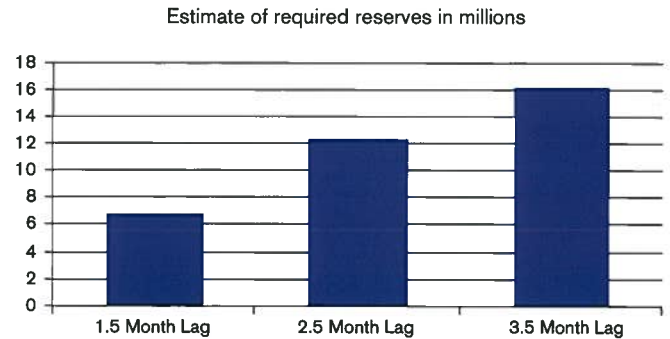
Of course, there will be a delay in billing while providers learn how to use the new codes. Fortunately, most providers use a small number of codes, so the learning curve, if steep, should be short.

The larger issue is the delay in reimbursement of claims, stemming from a decrease in productivity during the period of dual use of ICD-9 and ICD-10. Health plans need to account for time to do the mapping, as well as additional time for manual adjudication of unmapped codes.

Combined delays in billing and reimbursement may result in a growth in claim inventories, necessitating potentially substantial increases in required reserves. Because health lags are not that long (typically one to three months, depending on the claim type), adding weeks or months to the current payment lag could result in a large increase in required reserves. This is bad news for plans that are already struggling to maintain adequate reserves. The lag in billing and reimbursement will be greatest during the initial period of transition to ICD-10, but should subside as providers and plans acclimate to the new system.

The chart in Figure 1 was developed using claim data for an organization that typically has a claim-payment lag of 1.5 months. The reserves calculated for this organization were \$6.5 million. Using the same claim data, but factoring in a claim-payment lag of 2.5 or 3.5 months, the chart illustrates the dramatic increases in the organization's required reserves (\$12.3 million and \$16.2 million, respectively). While increasing reserves may have the greatest impact in the short term, this reality must also be accounted for when developing financial statements and projections.

Figure 1



Reimbursement roll call

Because the monetary value of a claim is based on the diagnosis or procedure (i.e., code) submitted on the claim, it is highly likely that mapping will have an impact on reimbursement. Because a single ICD-9 code may cross-walk to more than one ICD-10 code, payers must exercise care in deciding which code most accurately reflects how the services should be reimbursed.

A mapping of reimbursement from ICD-10 to ICD-9 is available from the Centers for Medicare & Medicaid Services (CMS) as a stopgap measure to accommodate systems that will not initially process claims using ICD-10. Each organization will need to test the standardized mapping to ensure that it is an appropriate structure for minimizing reimbursement anomalies and for facilitating claim adjudication.

CMS has initiated the process of converting Medicare severity diagnosis-related groups (MSDRGs) from ICD-9 to ICD-10. This development process is intended to reconcile situations where

WHAT ARE THE CHALLENGES AND OPPORTUNITIES POSED BY ICD-10 CONVERSIONS?

The U.S. Department of Health and Human Services has published a deadline of Oct. 1, 2013, for conversion from the ICD-9-CM coding standard to ICD-10. The new standard, already adopted in its core form by other countries around the world, provides richer coding, which will enhance clinical information for insurers, hospitals, researchers, and anyone else concerned with healthcare data. But the conversion poses significant organizational, technical, and budgetary challenges. For more information, go to milliman.com and search on "ICD-10."

a single ICD-9 code maps to several ICD-10 codes that may be in different diagnosis-related groups (DRGs). The development process includes a logical approach to selecting the appropriate code. Assuming that ICD-9 and ICD-10 temporarily run in parallel (i.e., organizations use cross-walks as a temporary measure for getting claims paid), then it is possible that a service may end up in a different DRG than if it had been billed using ICD-9 codes. One of the first things plans will need to do is look closely at their mix of MSDRGs paid before and after the transition to see if the mapping is impacting MSDRG-based payments.

The 80/20 problem

Despite efforts to implement cross-walks, there remains the problem of ambiguously translatable codes. A Milliman analysis of mapping ICD-9 codes to ICD-10 codes using historical health-plan claim data showed that about 80% of the claims mapped "cleanly." While this is a positive finding, there may be tremendous variation in the mapping of the remaining 20% of codes, for which there is no "clean" cross-walk. Even if the CMS reimbursement mapping becomes a widely accepted standard, there is an unknown effect of paying everything off of a single ICD-10 code, when in actuality there is a "multiple choice."

Health plans will also want to determine how changes in benefit-adjudication coding under the new system will specifically affect their organizations. For example, services with a claim edit identifying them as covered under ICD-9 may be identified as not covered under more specific ICD-10 service edits, or vice versa.

The adjustment period for ICD-10 will inevitably result in provider submission errors. Even though most providers use a very short list of common services and diagnoses, especially when compared to the thousands of available codes, providers will still make mistakes in selecting from the new codes and attempting to submit more accurate claims. At first, health plans are not likely to do any better than the providers, as they too will be getting accustomed to the new codes. In fact, some payers fear that, early on, providers will be more sophisticated in coding, and, until adjustments in reimbursement schemes can be made, will optimize reimbursement. That being said, the system will become more accurate over time as both providers and health plans learn the new codes and how to use them.

Reimbursement rates

Both payers and providers should expect some changes in reimbursement rates. We expect the greatest changes to be for hospital services related to the surgical approach. Because ICD-10 procedure codes are very specific when it comes to surgeries, providers and plans will be able to differentiate procedure intensity in a way that they cannot easily do under ICD-9. In general, after the chaotic transition period, ICD-10 will result in fewer miscoded, rejected, and improper reimbursement claims. But it may also result in a larger or smaller amount paid if the reimbursement scheme offers different payment amounts depending on the intensity level of the procedure or the severity of the condition.

Creating a new status quo

The transition to ICD-10 is unique in the history of the U.S. healthcare system. Despite the fact that we learned a great deal from the Y2K and HIPAA transitions, neither of these efforts equal what will be required for ICD-10. HIPAA and Y2K changed how data were transmitted and stored, and, in some small ways, how data were analyzed (i.e., limited data set). ICD-10 will change all of those things as well as every process, report, or analysis based on ICD-9. ICD-10 will have much more impact on how data are used in the delivery of healthcare.

This means one of two things. Either (1) the industry will establish a standardized approach to ICD-10 implementation, which will lead to more consistency among payers, or (2) there will be so many different approaches or interpretations (especially of codes unmapped or not cleanly mapped) that every plan's system will end up being different, resulting in additional chaos. Because health plans have typically modified "standard" systems to accommodate the unique characteristics of their own infrastructures, we think the latter will be the more likely future reality.

Large organizations, like most health insurance companies, are understandably concerned about the risks posed by major system changes such as ICD-10. Every change to a system or process, even those that may appear minor, introduces operational and financial risk. System modifications can be extremely complicated and expensive, and must be implemented with utmost care to ensure that downstream implications and unintended consequences are anticipated and mitigated. These realities can drive some in the industry to resist these kinds of changes. Still, the benefits can outweigh the risks, and innovative organizations are already strategizing about how to take full advantage of this conversion.

Benchmarking challenges

Another area that will be affected by the transition to ICD-10 will be utilization and cost benchmarking, and comparison of claims to those benchmarks. For a while, likely 18 months or longer, benchmark information will rely on mapped codes rather than actual billed data. During that time, organizations will not be able to perform one-to-one comparisons of actual utilization levels to benchmarks by procedure code. When billed ICD-10 benchmark data becomes available, revisions to benchmark schemes may be likely because ICD-10 provides so much more information than did ICD-9.

Although the claim process exemplifies the hurdles that health plans must leap in order to adopt ICD-10, it is only one of many issues demanding attention in the switch to a new system. ICD-9 and ICD-10 will likely have to run side by side for some time before the new system is steady enough to ride on its own.

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