ICD-10-CM and ICD-10-PCS Update

Session 2.03

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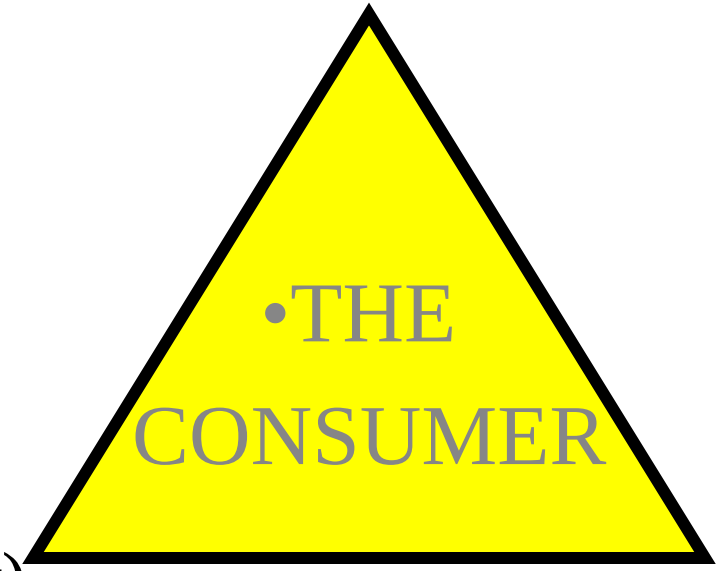
AGENDA

- Background on code sets
- Regulatory landscape
- Coding system characteristics
- Impacts
- WEDI recommendations
- Summary / Questions

BACKGROUND

THREE HEALTHCARE PERSPECTIVES

•PUBLIC HEALTH (Analytical)



•PROVIDER
(Care Delivery)

•PAYER
(Financial)

BACKGROUND

- International Classification of Diseases origins in Public Health
- Initially created to document Causes of Death (Mortality)
- Expanded later to include documentation of Causes of Disease, Injuries and Illness (ICD-1 through ICD-10)
- Adopted worldwide by World Health Organization member countries for the reporting of mortality
- Also adopted and used in WHO member countries by a wide variety of governments and organizations, such as health insurance companies, hospitals, military medical services, health administrators

BACKGROUND

- ICD-10 endorsed by the 34th World Health Assembly of the WHO in 1990
- WHO member countries started to use in 1994 for the reporting of mortality data
- The US adopted the use of ICD-10 for mortality reports in 1999
  - Mortality reports filed by states on a monthly basis
- Currently being used by more than 153 countries

BACKGROUND

- Alphabet Soup
  - ICD-9-CM: Clinical modification used in U.S. Developed in the 1970's, implemented 1979.
    - Volume 1&2 diagnosis codes (used by all providers)
    - Volume 3 procedure codes (used by hospitals for inpatient reporting).
  - ICD-10: Diagnosis classification system developed by the World Health Organization as a replacement to ICD-9. Implemented for mortality coding in the U.S. in 1999.

BACKGROUND

- Alphabet Soup
  - ICD-10-CM: Clinical modification for the ICD-10 diagnosis classification system developed by the U.S.
  - ICD-10-PCS: U.S. procedure classification system developed as a replacement to volume 3 of ICD-9-CM.
  - ICD-10-CA: Clinical modification for the ICD-10 diagnosis classification system developed by Canada.
  - ICD-10-AM: Clinical modification for the ICD-10 diagnosis classification system developed by Australia.

BACKGROUND

Alphabet Soup

- CPT: Current Procedural Terminology procedure coding system developed by the American Medical Association and used to report physician and other professional services as well as surgical procedures performed in hospital outpatient departments and other outpatient facilities
- SNOMED-CT: a comprehensive, multilingual, controlled clinical terminology, or common reference terminology.

BACKGROUND

- Rationale for adopting ICD-10-CM and ICD-10-PCS
  - ICD-9 classification is no longer supported by the WHO
  - 30 years old – no longer reflects modern clinical practice
  - Procedure codes running out of space in some sections – structure is being disrupted
  - Need it for EHR's
  - Need it for pay for performance
  - Public health/pandemic occurrences and bio-terrorism

BACKGROUND

- Rationale (continued):
- Improvement in
  - Benchmarking and quality management-to improve the quality, safety and effectiveness of patient care
  - Monitoring and controlling medical errors/patient safety issues
  - Decision-making (clinical, financial, funding, expansion, education)
  - Healthcare policy and public health tracking
  - Billing and reimbursement
  - Data quality and research
  - Trending and analyzing healthcare costs

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BACKGROUND

- Rationale for an extended transition timeframe:
  - Enormous effort will take time (think HIPAA)
  - Significant cost
  - Pilot
  - Prerequisites (e.g. v5010)
  - Significant education –physicians and other providers
  - Other mandates

REGULATORY LANDSCAPE

NCVHS Recommendations

- After 2 years of hearings, full NCVHS Committee issued recommendation November 2003 (letter available on NCVHS website)
- Initiate the regulatory process for the concurrent adoption of ICD-10-CM and ICD-10-PCS.
- Implementation period of at least two years following issuance of a final rule.
- Notice of Proposed Rule Making (NPRM), to specifically invite comments on the key issues presented in testimonies and letters before the Committee.

REGULATORY LANDSCAPE

NCVHS Questions:

- What could be done to minimize the costs of a transition to ICD-10-CM and ICD-10-PCS?
- What could be done to maximize the benefits of implementing ICD-10-CM and ICD-10-PCS?
- What are potential unintended consequences of such a migration, and how could they be mitigated?
- What timeframes would be adequate for implementation?
- What additional steps would be required to ensure a realistic and smooth migration?

REGULATORY LANDSCAPE

- Congressional activity
  - **H.R. 4157, the "Health Information Technology Promotion Act"**
    - Passed the House on 7/27/06
    - Directs HHS Secretary to require switch from ICD-9-CM to ICD-10-CM/PCS by October 1, 2010. NPRM not required
    - Directs HHS Secretary to require switch from current 4010 version of HIPAA transactions to v5010 by April 1, 2009. NPRM not required

REGULATORY LANDSCAPE

- Congressional activity
  - S. 1418, the "Wired for Health Care Quality Act"
    - Does not include provision to adopt ICD-10-CM and ICD-10-PCS.
    - Does not include provision to upgrade HIPAA transactions to v5010
    - Must be reconciled with H.R. 4157

REGULATORY LANDSCAPE

- Other regulatory activity:
  - Medicare contractor reform 2007-2009
  - HIPAA transactions version 5010
  - Other HIPAA mandates
    - National Provider Identifier
    - Claims attachments

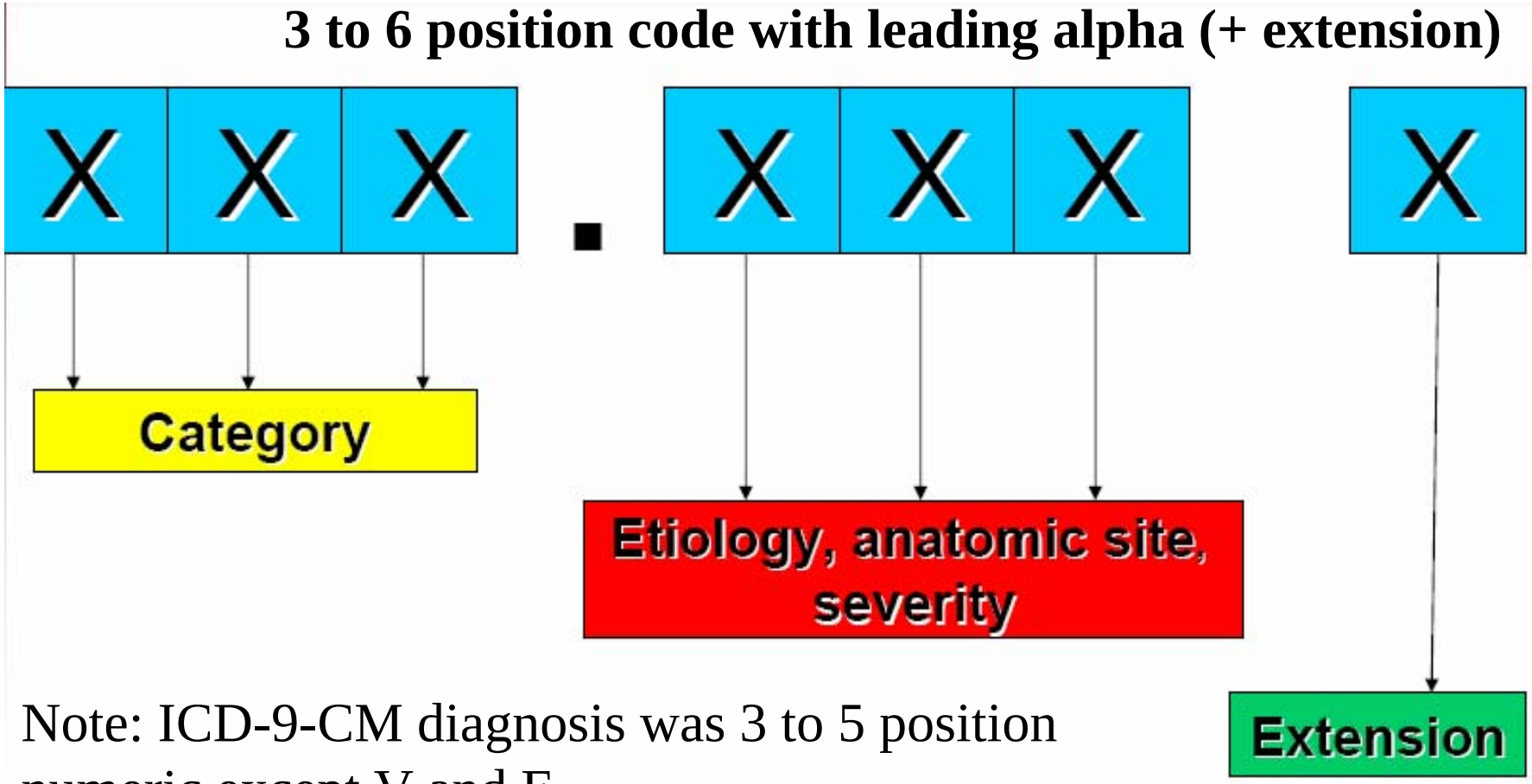
CODE SET CHARACTERISTICS

- Overview of ICD-10-CM
  - Alphanumeric codes
  - Restructured classification
  - Certain diseases have been reclassified to reflect current medical knowledge
  - Specificity and detail have been expanded
  - Expanded code length
  - New features added

ICD-10-CM is Massively More Complex than ICD-9-CM

ICD-10-CM Structure

3 to 6 position code with leading alpha (+ extension)



Note: ICD-9-CM diagnosis was 3 to 5 position numeric except V and E

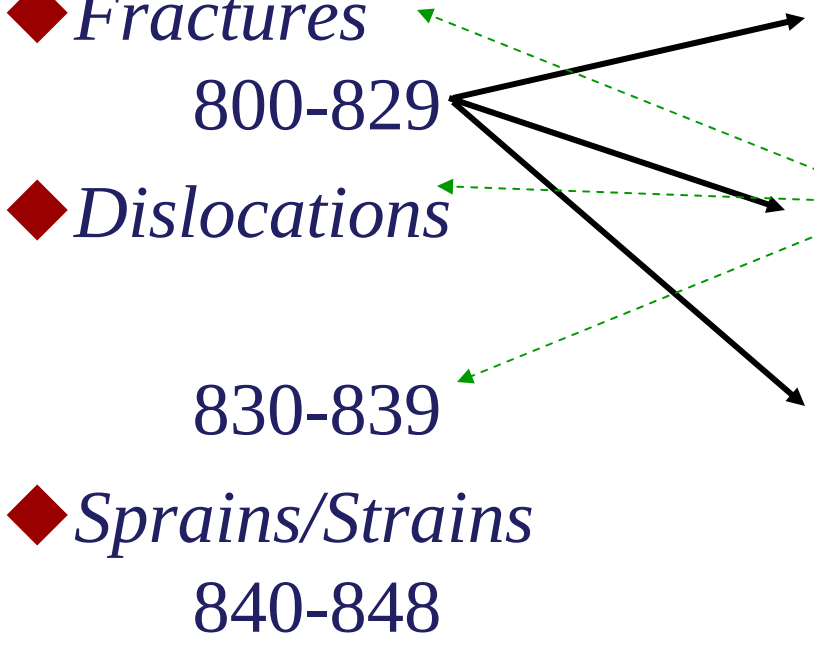
CODE SET CHARACTERISTICS

ICD-9-CM: By *type*

- *Fractures*
  800-829
- *Dislocations*
  830-839
- *Sprains/Strains*
  840-848

ICD-10-CM: By *location*

- Injuries to *head*
  S00-S09
- Injuries to *neck*
  S10-S19
- Injuries to *thorax*
  S20-S29



CODE SET CHARACTERISTICS

- ICD-9-CM (sample code)

438.11, Late effect of cerebrovascular disease, speech and language deficits, aphasia

733.01, Senile osteoporosis

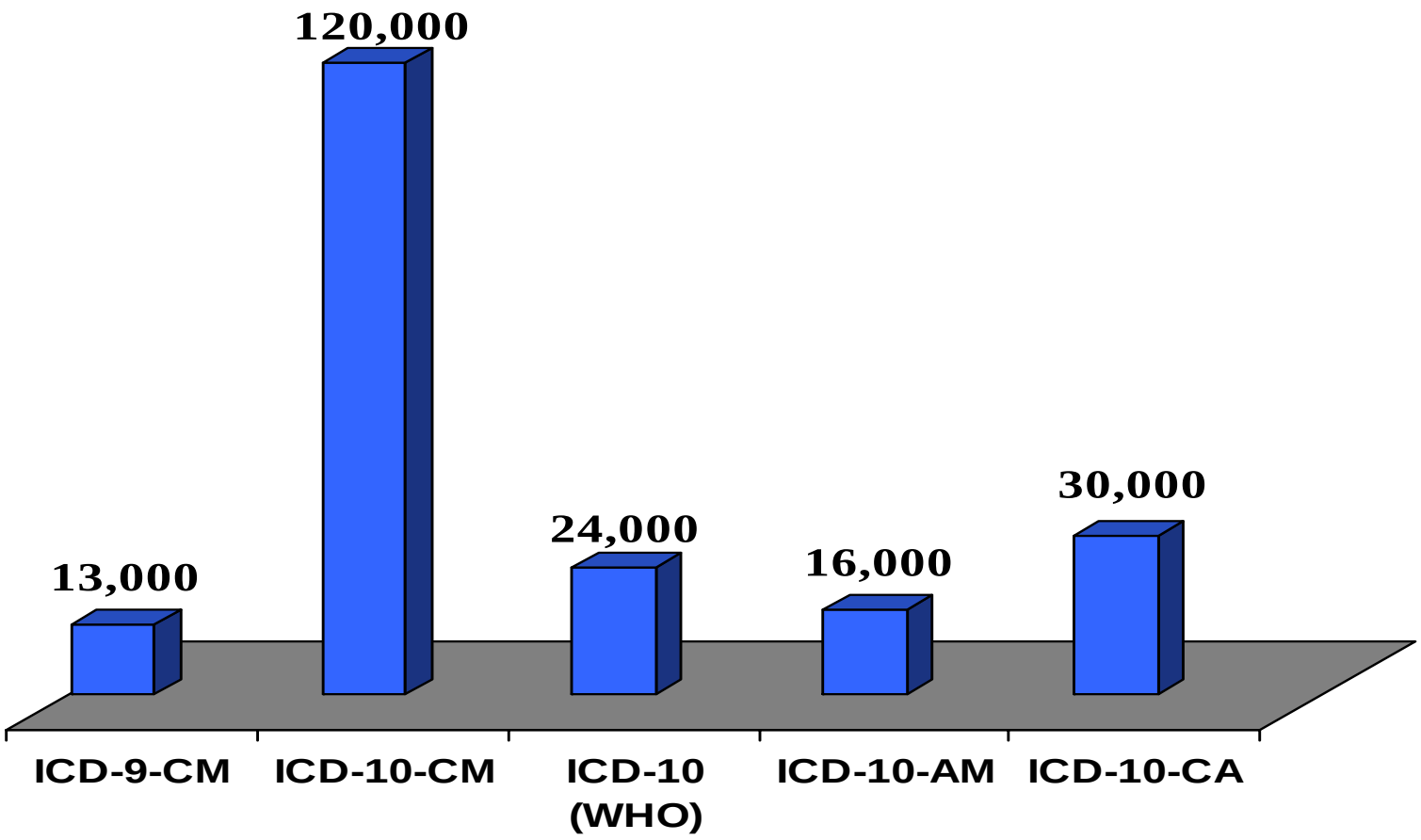
- ICD-10-CM (sample code)

I69.320, Speech and language deficits following cerebral infarction, Aphasia following cerebral infarction

M80.011a, Postmenopausal osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture

CODE SET CHARACTERISTICS

Code Set Counts - Diagnosis



Diagnosis Codes For Asphyxiation: ICD-9 v ICD-10

1 ICD-9 Code

Asphyxiation and strangulation (994.7)

Includes suffocation by bedclothes, cave-in, constriction, mechanical, plastic bag, pressure, strangulation

39 ICD-10-CM Detail Codes

- Asphyxiation due to smothering under pillow, accidental (T71.111)
- Asphyxiation due to smothering under pillow, intentional self-harm (T71.112)
- Asphyxiation due to smothering under pillow, assault (T71.113)
- Asphyxiation due to smothering under pillow, undetermined (T71.114)
- Asphyxiation due to plastic bag, accidental (T71.121)
- Asphyxiation due to plastic bag, intentional self-harm (T71.122)
- Asphyxiation due to plastic bag, assault (T71.123)
- Asphyxiation due to plastic bag, undetermined (T71.124)
- Asphyxiation due to smothering under another person's body (in bed), accidental (T71.141)
- Asphyxiation due to smothering under another person's body (in bed), assault (T71.143)
- Asphyxiation due to smothering under another person's body (in bed), undetermined (T71.134)
- Asphyxiation due to smothering in furniture, accidental (T71.151)
- Asphyxiation due to smothering in furniture, intentional self-harm (T71.152)
- Asphyxiation due to smothering in furniture, assault (T71.153)
- Asphyxiation due to smothering in furniture, undetermined (T71.154)
- Asphyxiation due to hanging, accidental(T71.161)
- Asphyxiation due to hanging, intentional self-harm (T71.162)
- Asphyxiation due to hanging, assault (T71.163)
- Asphyxiation due to hanging, undetermined (T71.164)
- Asphyxiation due to being trapped in bed linens , intentional self-harm (T71.132)
- Asphyxiation due to being trapped in bed linens, assault (T71.133)
- Asphyxiation due to being trapped in bed linens , undetermined
- Asphyxiation due to mechanical threat to breathing due to other causes, accidental (T71.191)
- Asphyxiation due to mechanical threat to breathing due to other causes, intentional self-harm (T71.192)
- Asphyxiation due to mechanical threat to breathing due to other causes, assault (T71.193)
- Asphyxiation due to mechanical threat to breathing due to other causes, undetermined (T71.194)
- Asphyxiation due to systemic oxygen deficiency due to low oxygen content in ambient air due to unspecified cause(T71.221)
- Asphyxiation due to cave-in or falling earth (T71.192)
- Asphyxiation due to mechanical threat to breathing due to other causes, assault (T71.21)
- Asphyxiation due to being trapped in a car trunk, accidental (T71.221)
- Asphyxiation due to being trapped in a car trunk, intentional self-harm (T71.222)
- Asphyxiation due to being trapped in a car trunk, assault (T71.223)
- Asphyxiation due to being trapped in a car trunk, undetermined (T71.224)
- Asphyxiation due to being trapped in a (discarded) refrigerator, accidental (T71.231)
- Asphyxiation due to being trapped in a (discarded) refrigerator, intentional self-harm (T71.232)
- Asphyxiation due to being trapped in a (discarded) refrigerator, assault (T71.233)
- Asphyxiation due to being trapped in a (discarded) refrigerator, undetermined (T71.234)
- Asphyxiation due to being trapped in other low oxygen environment (T71.29)
- Asphyxiation due to

Diagnosis Codes For Sports Injury Caused By Striking Against Or Being Struck

24 ICD-10-CM Detail Codes
+9 Higher Level

1 ICD-9 Code

Striking against or struck accidentally in sports without subsequent fall (E917.0)

Includes kicked or stepped on during game (football) (rugby), struck by hit or thrown ball, struck by hockey stick or puck

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
W21.11 Struck by baseball bat
W21.12 Struck by tennis racquet
W21.13 Struck by golf club
W21.19 Struck by other bat, racquet or club
W21.210 Struck by ice hockey stick
W21.211 Struck by field hockey stick
W21.220 Struck by ice hockey puck
W21.221 Struck by field hockey puck
W21.81 Striking against or struck by football helmet
W21.89 Striking against or struck by other sports equipment
W21.9 Striking against or struck by unspecified sports equipment

CODE SET CHARACTERISTICS

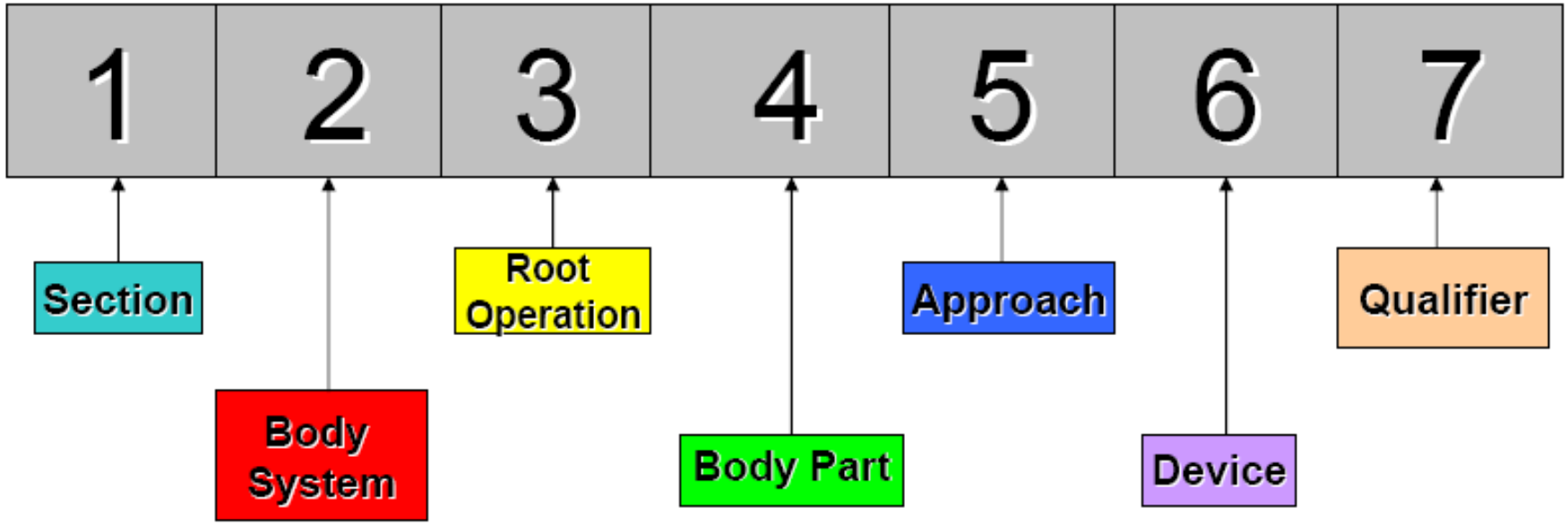
Overview of ICD-10-PCS

- Alphanumeric codes
- Ability to aggregate codes across all essential components of a procedure.
- Multi-axial structure with each code character having the same meaning within the specific procedure section and across procedure sections
- New procedures and technologies are easily incorporated.
- All terminology is precisely defined and used consistently across all codes.

ICD-10-PCS is Massively More Complex than ICD-9-CM

ICD-10-PCS Structure

7-position alphanumeric code



Note: ICD-9-CM procedure code was 2 to 4 position numeric

CODE SET CHARACTERISTICS

- ICD-9-CM (sample code)

  47.01 Laparoscopic appendectomy

- ICD-10-PCS (sample code)

  Laparoscopic appendectomy
  0DTJ4ZZ

  0 - Medical and Surgical Section

  D - Gastrointestinal system

  T - Resection (root operation)

  J - Appendix (body part)

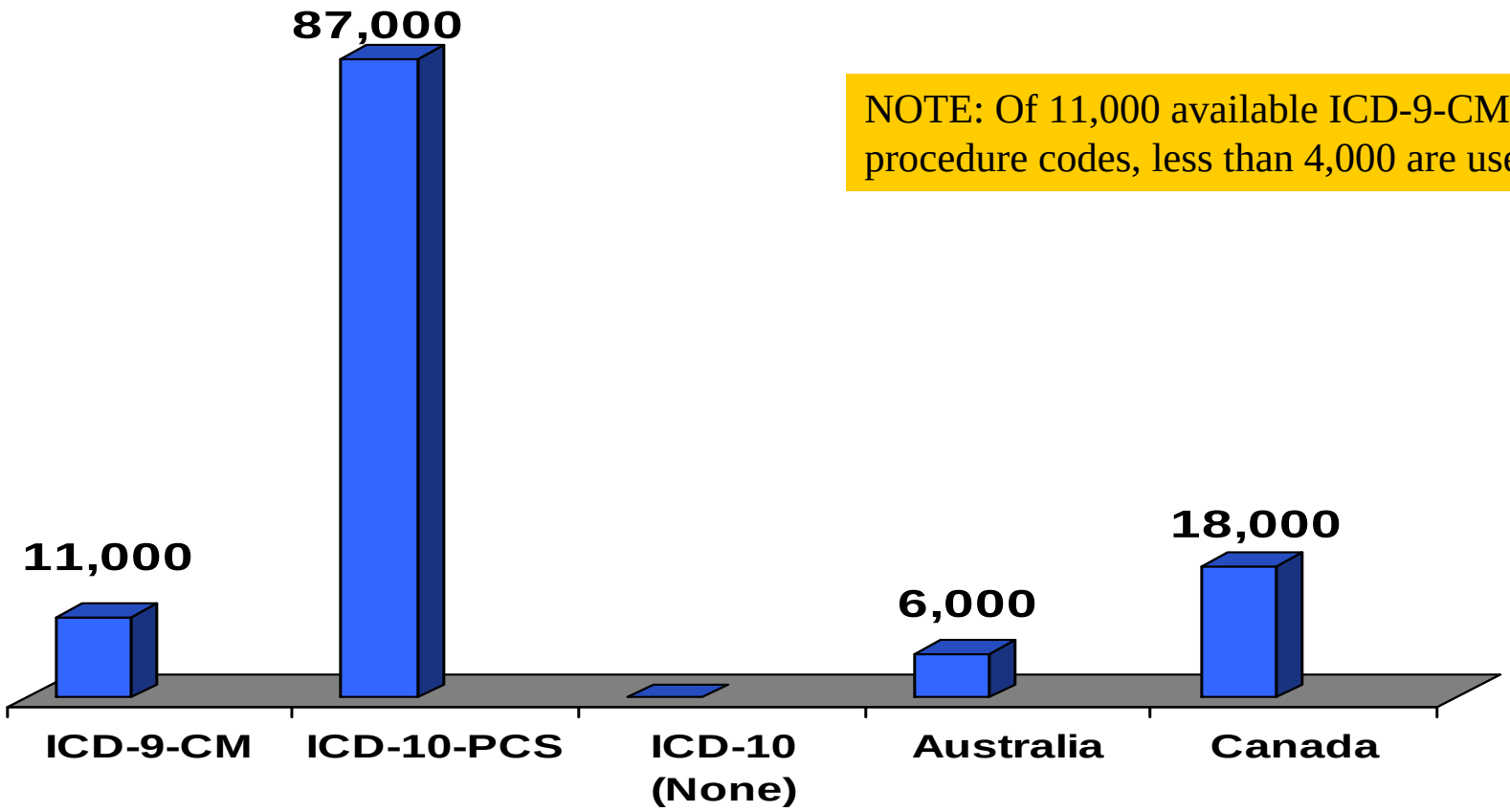
  4 - Percutaneous endoscopic (approach)

  Z - Without device

  Z - Without qualifier

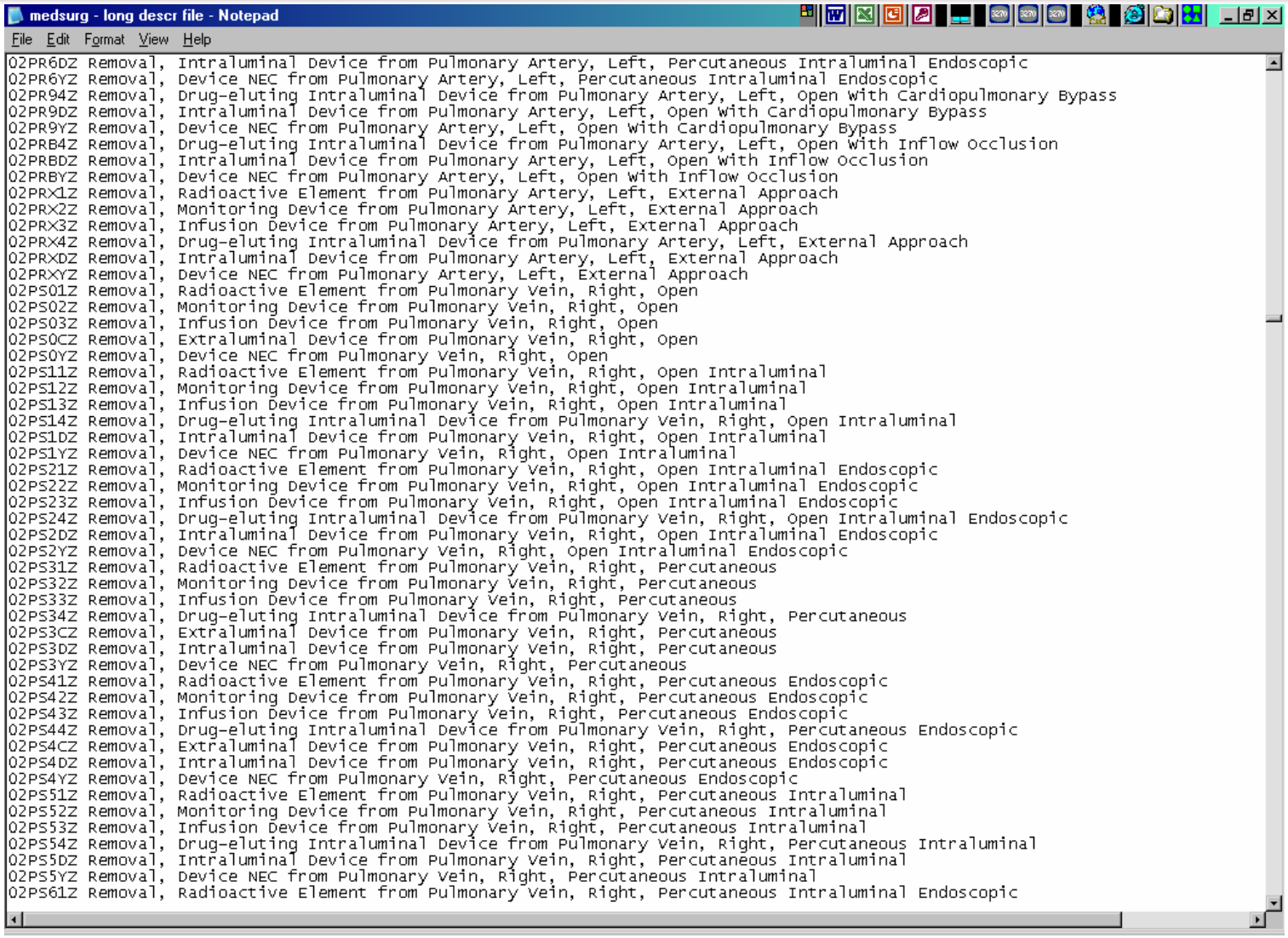
CODE SET CHARACTERISTICS

Code Set Counts - Procedure



NOTE: Of 11,000 available ICD-9-CM procedure codes, less than 4,000 are used

CODE SET CHARACTERISTICS



medsurg - long descr file - Notepad

File Edit Format View Help

```
02PR6DZ Removal, Intraluminal Device from Pulmonary Artery, Left, Percutaneous Intraluminal Endoscopic
02PR6YZ Removal, Device NEC from Pulmonary Artery, Left, Percutaneous Intraluminal Endoscopic
02PR94Z Removal, Drug-eluting Intraluminal Device from Pulmonary Artery, Left, Open With Cardiopulmonary Bypass
02PR9DZ Removal, Intraluminal Device from Pulmonary Artery, Left, Open With Cardiopulmonary Bypass
02PR9YZ Removal, Device NEC from Pulmonary Artery, Left, Open With Cardiopulmonary Bypass
02PRB4Z Removal, Drug-eluting Intraluminal Device from Pulmonary Artery, Left, Open With Inflow Occlusion
02PRBDZ Removal, Intraluminal Device from Pulmonary Artery, Left, Open With Inflow Occlusion
02PRBYZ Removal, Device NEC from Pulmonary Artery, Left, Open With Inflow Occlusion
02PRX1Z Removal, Radioactive Element from Pulmonary Artery, Left, External Approach
02PRX2Z Removal, Monitoring Device from Pulmonary Artery, Left, External Approach
02PRX3Z Removal, Infusion Device from Pulmonary Artery, Left, External Approach
02PRX4Z Removal, Drug-eluting Intraluminal Device from Pulmonary Artery, Left, External Approach
02PRXDZ Removal, Intraluminal Device from Pulmonary Artery, Left, External Approach
02PRXYZ Removal, Device NEC from Pulmonary Artery, Left, External Approach
02PS01Z Removal, Radioactive Element from Pulmonary Vein, Right, Open
02PS02Z Removal, Monitoring Device from Pulmonary Vein, Right, Open
02PS03Z Removal, Infusion Device from Pulmonary Vein, Right, Open
02PS0CZ Removal, Extraluminal Device from Pulmonary Vein, Right, Open
02PS0YZ Removal, Device NEC from Pulmonary Vein, Right, Open
02PS11Z Removal, Radioactive Element from Pulmonary Vein, Right, Open Intraluminal
02PS12Z Removal, Monitoring Device from Pulmonary Vein, Right, Open Intraluminal
02PS13Z Removal, Infusion Device from Pulmonary Vein, Right, Open Intraluminal
02PS14Z Removal, Drug-eluting Intraluminal Device from Pulmonary Vein, Right, Open Intraluminal
02PS1DZ Removal, Intraluminal Device from Pulmonary Vein, Right, Open Intraluminal
02PS1YZ Removal, Device NEC from Pulmonary Vein, Right, Open Intraluminal
02PS21Z Removal, Radioactive Element from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS22Z Removal, Monitoring Device from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS23Z Removal, Infusion Device from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS24Z Removal, Drug-eluting Intraluminal Device from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS2DZ Removal, Intraluminal Device from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS2YZ Removal, Device NEC from Pulmonary Vein, Right, Open Intraluminal Endoscopic
02PS31Z Removal, Radioactive Element from Pulmonary Vein, Right, Percutaneous
02PS32Z Removal, Monitoring Device from Pulmonary Vein, Right, Percutaneous
02PS33Z Removal, Infusion Device from Pulmonary Vein, Right, Percutaneous
02PS34Z Removal, Drug-eluting Intraluminal Device from Pulmonary Vein, Right, Percutaneous
02PS3CZ Removal, Extraluminal Device from Pulmonary Vein, Right, Percutaneous
02PS3DZ Removal, Intraluminal Device from Pulmonary Vein, Right, Percutaneous
02PS3YZ Removal, Device NEC from Pulmonary Vein, Right, Percutaneous
02PS41Z Removal, Radioactive Element from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS42Z Removal, Monitoring Device from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS43Z Removal, Infusion Device from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS44Z Removal, Drug-eluting Intraluminal Device from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS4CZ Removal, Extraluminal Device from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS4DZ Removal, Intraluminal Device from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS4YZ Removal, Device NEC from Pulmonary Vein, Right, Percutaneous Endoscopic
02PS51Z Removal, Radioactive Element from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS52Z Removal, Monitoring Device from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS53Z Removal, Infusion Device from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS54Z Removal, Drug-eluting Intraluminal Device from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS5DZ Removal, Intraluminal Device from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS5YZ Removal, Device NEC from Pulmonary Vein, Right, Percutaneous Intraluminal
02PS61Z Removal, Radioactive Element from Pulmonary Vein, Right, Percutaneous Intraluminal Endoscopic
```

CODE SET CHARACTERISTICS

- Crosswalks between ICD-9-CM and ICD-10-CM/PCS will be available
  - Backward and forward maps between ICD-9-CM procedures and ICD-10-PCS are currently available on CMS web site and updated annually
  - Map from ICD-10-CM to ICD-9-CM is under development by National Center for Health Statistics (NCHS)
  - Map from SNOMED-CT to ICD-10-CM will be developed

Automated crosswalks are essential to assure consistency and prevent:

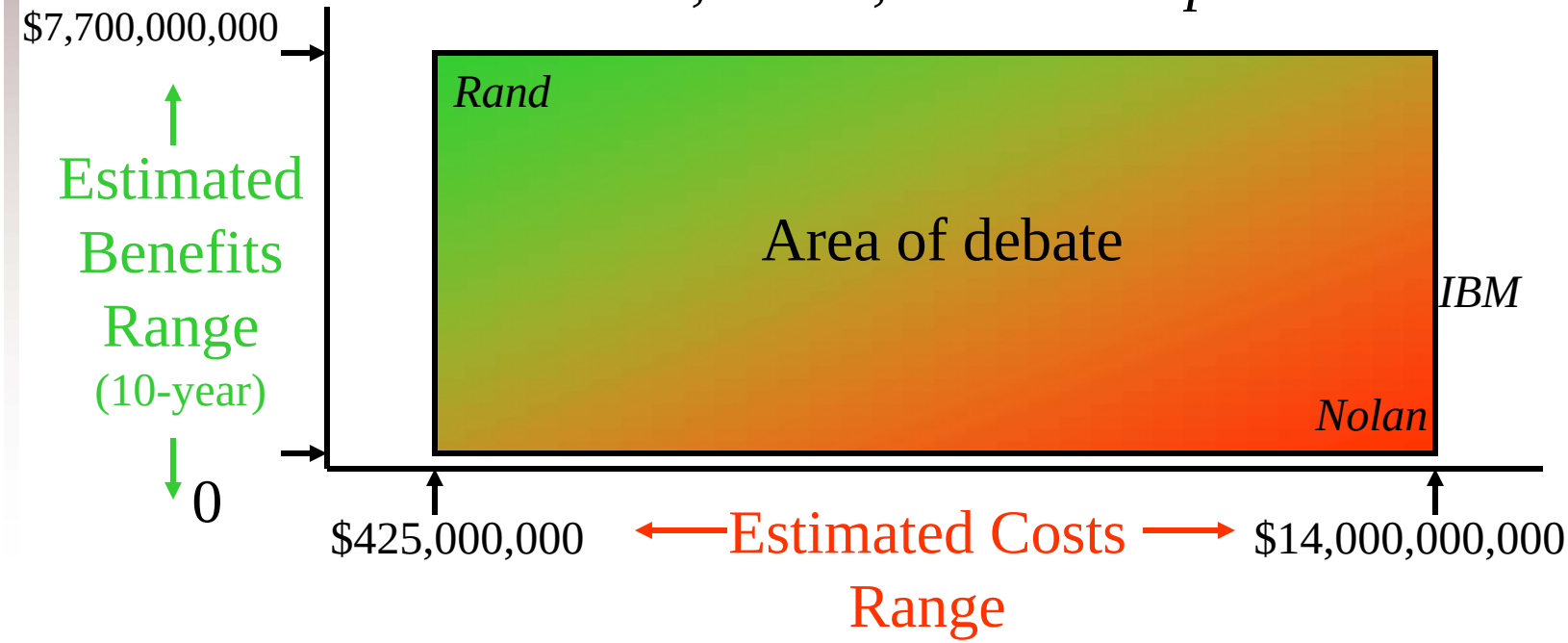
- **Loss of historical data**
- **Inability to run incentive programs**
- **Improper payments, fraud and abuse**

IMPACTS

Cost vs. Benefit of ICD-10-CM and ICD-10-PCS

Wide variability of cost range and benefit range.
Projected benefits would be long term.

Rand, Nolan, and IBM reports



IMPACTS

Cost: Summary of Upper Bound Estimates for System Changes

- Hospitals (& vendors)
  - Rand: $320 m/ Estimated average of $60,000
  - Nolan: $6 b/ Estimated average of $1.2 m
- Payers
  - Rand: $250 m
  - Nolan: $1 b
- Physicians
  - Rand: n/a
  - Nolan: $2.2 b
- CMS
  - Rand: $125 m
  - Nolan: $1.4 b

Cost: Perspectives on Estimates for Payers System Changes

- Rand estimates suggest $94 m in systems costs for Blue plans

- HIPAA TCS cautionary experience
  - HHS Impact Analysis: $/Payer approximately $1 m
  - HIPAA TCS Actual (from survey of small to mid-sized plans): $21 m (ranging from $6 m to $34 m)
  - No ROI

- NPI cautionary experience
  - A 4 m member Plan reports >$20 m

IMPACTS

IMPLEMENTATION ISSUES

- Industry-wide impact
- Cost could approach Y2K or HIPAA Transactions and Code Sets
- Cost / benefits not demonstrated
- Significant transitional concerns
- On the heels of other HIPAA implementation

IMPACTS

WHO WOULD BE IMPACTED?

- Payers
- Providers, Pharmacies, Laboratories
- Researchers
- Vendors
- Clearinghouses / TPA's
- Employers, Members
- Suppliers
- Other Business Partners

IMPACTS

WHAT ARE THE IMPACTS?

- Software / Packages
- Reimbursement / Contracting
- Procedures / Treatment Policies
- Training
- Forms
- Statistics / Reporting / Research
- Transactions
- Transition
- Other?

IMPACTS

PAYER SOFTWARE

- Changes to format, logic, business rules
  - Screens, DB's, Files, Reports, Queries, Edits, Mapping
  - Adjudication, Reimbursement, Other Logic
  - Authorization, Actuarial, Case Management/UM
  - Customer and other external reporting
- Changes to purchased software
  - Groupers, Special Edits (e.g. medical necessity, bundling), Statistics, Reference
- Other Changes
  - OCR, VRU, Web
- EXTENSIVE TESTING!!!!!!

PROVIDER SOFTWARE

- Impacts to purchased software or tools built in-house
  - Scheduling
  - Billing
  - Claims Submission
  - Finance / Performance
  - Intensive Care / ER Activity

IMPACTS

VENDOR SOFTWARE

- Update software (same types of changes as described earlier)
  - Decision Support Systems
  - Billing / Practice Management
  - Medical Necessity,Clinical
  - Managed Care / HEDIS, Other Quality Reporting
- Update Documentation
- Negotiate with Supported Sites
- Install / Convert / Train

IMPACTS

REIMBURSEMENT

- Payer:
  - Impact to DRG's, APC's, line pricing by procedure, contract negotiations/fee schedules (thousands), revise and distribute materials, RBRVS
- Provider:
  - Impact to fee schedules/contracts, new billing software, coding changes, extensive documentation, practice costs/projections, cash flow
- Employer / Member:
  - Impact to ASO contracts, special customer arrangements, coinsurance, riders

IMPACTS

PROCEDURES

- Payer
  - Documentation, Hard Copy, Error Correction
  - Timeliness, Fraud, Case Management Policies
  - Reimbursement Policies, Underwriting
- Provider
  - Treatment Policies, Authorizations / Referrals
  - Coding, Increased Documentation Specificity
  - Hard Copy
- Other
  - Clearinghouse, TPA, Lab, Pharmacy, Employer
  - Anyone dealing with diagnosis / procedure codes.

IMPACTS

TRAINING

- Payer
  - Claims Processors, Administrative Staff, I/S
  - Medical Review Staff, Actuaries
  - Auditors, Fraud Investigators
- Provider
  - Doctors / Nurses, Administrative Staff
  - Billing
- Other
  - Lab, Employee Benefits Administrators
  - Other Vendors and Service Providers
- PRODUCTIVITY LOSSES MAY OCCUR

IMPACTS

FORMS

- Provider Visit Sheets
- HCFA 1500 / 1450
- Other

IMPACTS

STATISTICS

- Trend Analysis
- Utilization Management
- Rating
- Quality of Care / Disease Management
- HEDIS / Customer Reports
- Provider Profiling
- Ad Hoc

TRANSITION

- Dual Standards
- Archived Data, Medical Records
- Distorted / Lost Statistics
- Rating / Fees
- Hard Copy
- NCQA, HEDIS, Employer Reporting
- Cross Year Functions, Hospitalizations
- Business Associates
- Trading partner testing and migration
- Etc.

IMPACTS

OTHER CONSIDERATIONS

- Fraud
- Cash Flow
- Patient Treatment
- Cost / Benefit
- Industry-Wide Evaluation
- Is this only an interim step?

WEDI RECOMMENDATIONS

- WEDI forum was held to address ICD-10-CM and ICD-10-PCS implementation concerns
  - Provide background on these code sets
    - All ICD-10's are not the same
    - ICD-10-CM and ICD-10-PCS should not be confused with ICD-10, ICD-10-CA, ICD-10-AM, etc.
    - Each coding system has vastly different numbers of codes and/or formats
  - Determine what would need to be done if these code sets were adopted

WEDI RECOMMENDATIONS

- Purpose of the forum:
  - **Was NOT to debate the merits of ICD-10-CM and ICD-10-PCS**
    - Rand report and Nolan report had different conclusions
    - WEDI has not established a position
  - **It was**
    - to provide information on what these coding systems entail
    - To gather input on how these coding systems might be implemented if mandated
    - To identify considerations that must be addressed

WEDI RECOMMENDATIONS

- Results: What timeframes would be adequate?
  - Establishing a target date is important
  - The date needs to be reasonable- the 2009 date is not reasonable [Note: H.R. 4157 now reflects 2010]
  - The industry needs to identify implementation steps and dependencies in order to determine an appropriate time frame.
  - Timeframes should allow for a notice and comment period.

WEDI RECOMMENDATIONS

- Results: How to Minimize the Transition Costs?
  - Identify a series of interim steps each with a timeline leading up to the overall target date.
  - Implementing the next version of the transaction standard (5010) should occur first.
  - Consider the impact to HIT and other industry initiatives when determining a target date. Priorities must be set.
  - Create a single source (preferably automated site) for ICD-10-CM and ICD-10-PCS code set dissemination, crosswalk and maintenance materials.
  - (continued…)

WEDI RECOMMENDATIONS

- Results: How to Minimize the Transition Costs?
  - (…continued)
  - Request that HHS provide software to allow the industry to incorporate ICD-10-CM and ICD-10-PCS automated crosswalks.
  - Ensure that additional crosswalks for SNOMED to ICD-10 are developed. The role of SNOMED should be clarified.
  - Develop a core set of educational and outreach programs.
  - Conduct extensive education & outreach (key lessons learned from 004010 and NPI).

WEDI RECOMMENDATIONS

- Results: What opportunities could be created to take advantage of the benefits
  - Attendees indicated that benefits would likely be long term in nature.
  - Prioritizing industry initiatives could help maximize benefits.

WEDI RECOMMENDATIONS

- Results: What additional steps would be required?
  - Pilot testing is valuable; funding for pilots would be needed.
  - Establish a series of templates to conduct ICD-10-CM and ICD-10-PCS pilot testing.
  - Tools such as vendor software upgrades will be needed in order to support pilot activities.
  - Templates for impact analysis would assist entities in assessing the potential impacts.
  - Code set usage/applicability guidelines are needed; handling of paper claims should be included.
  - Government resources would be needed.

WEDI RECOMMENDATIONS

- Results: Role of WEDI
  - Develop recommended implementation sequence, dependencies, and timeline
  - Develop templates for pilot testing and impact assessment
  - Assist with education and outreach
  - *Help to address issues related to the standards update process*

WEDI RECOMMENDATIONS

Results: Role of HHS

- HHS should clarify its priorities regarding HIT initiatives, HIPAA transactions and identifiers and any other related items. With limited resources and competing objectives, the industry needs to focus on what is most critical.
- HHS should review the HIPAA experience to identify what measures worked and what measures were not effective. A lessons-learned exercise would be beneficial.

WEDI RECOMMENDATIONS

- Steps Taken:
  - Report of forum distributed to WEDI board.
  - Report of forum posted to WEDI web site
  - Report presented at May WEDI conference
  - Recommendations sent to HHS and others

SUMMARY:

- VERY BIG CHANGE
- HIGH IMPACT / RISK
- HIGH COSTS
- IMPLICATIONS NOT FULLY DEFINED
- APPROACH WITH CAUTION AND KNOWLEDGE
- 2010 IS TOO SOON

THANK YOU

????????QUESTIONS????????