

*ICD-10 - A STRATEGIC APPROACH FOR
STATE MEDICAID AGENCIES*
A CNSI - WHITE PAPER

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INTRODUCTION

This CNSI white paper explores the International Classification of Diseases 10th Edition (ICD-10) as it relates to compliance efforts for State Medicaid Agencies (SMAs). CNSI presents the critical elements of the Health Insurance Portability and Accountability Act (HIPAA) ICD-10 legislation and the opportunities, both short- and long-term, ICD-10 presents. This paper explains how CNSI's proprietary ICD-10 compliance framework and related methodologies and technologies leverage the Centers for Medicaid and Medicare (CMS) Medicaid Information Technology Architecture (MITA) to accomplish the goals of ICD-10 remediation. The CNSI methodology outlined in this paper emphasizes the essential early activities necessary for the foundation of successful SMA compliance efforts.

CNSI presents this material in five sections. In Section 1 CNSI presents a brief history of the ICD-10 legislation and the future legislative initiatives that are dependent upon ICD-10. Section 2 introduces CNSI's proprietary six-stage ICD-10 compliance framework and potential remediation approaches. In Section 3 CNSI presents opportunities and benefits SMAs can derive through ICD-10 compliance. This includes general strategic opportunities and benefits (both short- and long-term) and the specific benefits and opportunities for SMAs using CMS's MITA framework. In Section 4, CNSI presents more details on the essential early stage activities in the remediation program including the ICD-10 assessment and the development of the translation strategy and related technology tools. Section 5 summarizes the content of the document and provides the list of endnotes.

As a basis for discussion of ICD-10 with respect to the MITA Framework we have assumed the reader understands:

- CMS's MITA framework
- Structural differences between ICD-9 and ICD-10

State Medicaid Agencies are the primary audience for this document; however CNSI's proprietary technologies span the marketplace, providing value to both public and private payers. The audience this document will find most value are the following:

- State Medicaid Agencies
- Private Sector Insurance Companies
- Clearinghouses
- Health Providers
- Health Care Payers
- Health Technology Providers
- Health Care Consultants

SECTION 1 - OVERVIEW

1.1 ICD-10 – A BRIEF HISTORY

The International Classification of Disease, Ninth edition (ICD-9) has been in use since 1979 with annual revisions. ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and was adopted by most World Health Organization (WHO) members in 1994. The United States is one of the few developed countries that have yet to complete the transition to ICD-10.

In August 2008, the United States Department of Health and Human Services (HHS) proposed that new code sets be used for reporting diagnoses and hospital inpatient procedures on health care transactions in the United States. The proposed rule was published for review on August 22, 2008. On January 16, 2009, the Health and Human Services (HHS) published a final rule establishing ICD-10 as the new national coding standard with a compliance date of October 1, 2013. The final rule is Federal Regulation 45 CFR Part 162.

By the compliance date the Centers for Medicare and Medicaid Services (CMS), including the, Children’s Health Insurance Program (CHIP), Survey and Certifications (CMCS), and all public and private payers and providers, must transition to the ICD-10 clinical modification (ICD-10-CM) for diagnosis, and ICD-10 Procedure Coding System (ICD-10-PCS) for inpatient procedure codes, from the current ICD-9-CM / ICD-9-PCS code set. SMAs and other covered entities, as defined in HIPAA, must transition to ICD-10 for use on all transaction dates of service or discharge on and after October 1, 2013.

The transition to ICD-10 will affect every system, process, and transaction that contains or uses a diagnosis or inpatient procedure code. The impacts will depend on the remediating entity’s strategic vision to leverage data in the future. Possible strategies include Direct Implementation, Partial Direct Implementation and the Crosswalk Approach, which are described in further detail in Section 3.2. Direct effects to SMAs include: coverage determinations, payment determinations, medical review policies, plan structures, statistical reporting, actuarial projects, fraud and abuse monitoring, and quality measurement.ⁱ

Broadly explained, the new coding system will enhance the accurate payment for services rendered (reimbursement) and will facilitate evaluation of medical processes and outcomes (quality). Using the CNSI Framework, methodologies and proprietary tools, SMAs will achieve those benefits, while addressing the areas directly affecting their business processes.

1.2 FUTURE LEGISLATION DEPENDENT UPON ICD-10

The various Health Information Technology (HIT) and Health Information Exchange (HIE) initiatives with direct dependencies on the ICD-10 transition include the followingⁱⁱ:

- Modifications to HIPAA transaction standards

- Implementation of the American Recovery and Reinvestment Act (ARRA)
 - Development of State HIT/HIE Plans to develop and advance mechanisms for information sharing across the health care system, including establishing HIE capacity among health care providers and hospitals in their jurisdiction, ultimately enabling exchange among states
 - Implementation of Medicaid Electronic Health Records (EHR) incentive programs, including State Medicaid Health Information Technology Plan (SMHP), APDs, and alignment with the State's MITA self-assessment
 - Beacon community grants for selected communities to build and strengthen their health information technology infrastructure and exchange capabilities
 - Meaningful Use requires States to implement ways to automate e.g., exchange health record information between providers and health plans instead of requesting paper records or requiring attachments to prior authorization requests
 - HIT Regional Extension Centers (RECs) will offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs. The consistent nationwide adoption and use of secure EHRs will ultimately enhance the quality and value of health care
 - Extension of broadband internet access to rural providers
 - Assistance to safety net providers, including Community Health Centers (CHCs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and tribal facilities to implement HIT/EHR technology
- Implementation of Affordable Care Act (ACA)
 - Administrative Simplification
 - American Health Benefit Exchanges
 - Fraud, Waste, and Abuse
 - Medicaid Expansion
 - Patient Centered Medical Home (PCMH)
 - Accountable Care Organization (ACO)
- Maturation of MMIS systems within CMS' MITA Framework
- Value Based Purchasing (VBP)
- State-specific Quality Improvement Organizations, External Quality Review Organizations, and patient registries (e.g., immunization registries)
- Improvements in public health coordination, including the National Electronic Disease Surveillance System (NEDSS)

SECTION 2– CNSI’S ICD-10 STRATEGIC FRAMEWORK

2.1 INTRODUCTION TO THE CNSI STRATEGIC FRAMEWORK

There are many industry established frameworks for ICD-10 compliance. However, based on CNSI’s public sector experiences none of the established industry approaches align with the unique needs of SMAs. CNSI developed an ICD-10 framework that leverages the MITA business architecture already being used by the SMAs for self-assessment and other CMS initiatives.

CNSI’s strategic framework shows the major steps to ensure ICD-10 Compliance. Using this framework in conjunction with CNSI’s proprietary technologies will ensure that the SMA is positioned to take full advantage of future legislation dependent upon ICD-10 process, systems and policies. The framework is intended to follow a sequential approach. A sequential approach will ensure high quality and management effectiveness for the SMA’s ICD-10 initiative. Figure 1 shows the primary components of the framework as a series of interdependent phases from left to right. Phase 1 through 3, outlined in gold color, show the period when translation strategies and supporting translation technologies should be selected and deployed. Relative timeframes are provided for each phase along with the high-level descriptions.

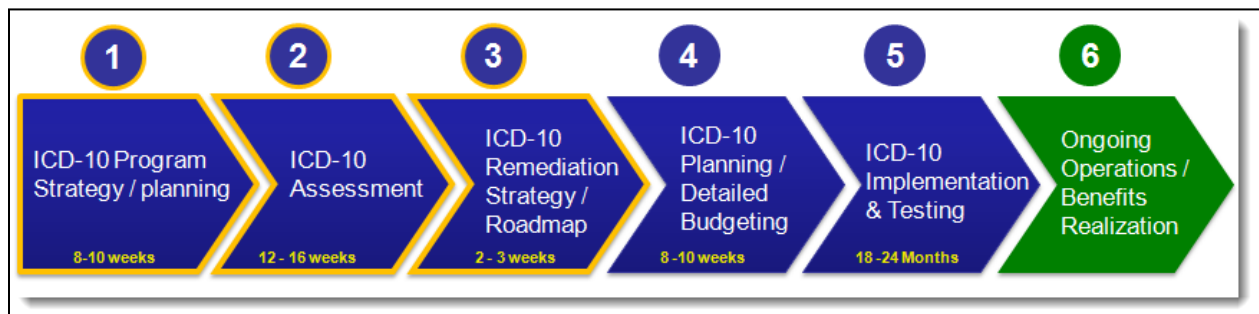


Figure 1.CNSI’s ICD-10 Framework

In developing our ICD-10 strategic framework, CNSI considered the content of CMS’s Enhanced Funding Requirements: Seven Standards and Conditionsⁱⁱⁱ. We have leveraged the MITA standard in Phase 1 through 4 of the Framework. Use of the MITA business architecture allows the SMA to reuse the data already available as a result of the completion of the SMA’s MITA self-assessment. For SMAs who have not yet completed their MITA self-assessment, CNSI’s ICD-10 framework provides the structure and data that can be reused for the MITA self-assessment.

Beginning with the strategy and planning in Phase 1, CNSI uses the MITA business process structure to organize and document the SMA’s business processes, technologies, and business partners for the assessment to be completed in Phase 2. In Phase 2, CNSI uses the MITA business process architecture to interpret the SMA’s organization structure, training requirements, and business functions affected by

the implementation of the ICD-10 regulations. In Phase 3 and 4, the MITA business architecture is again employed to develop detailed requirements and the related Advance Planning Documentation for budgeting development and implementation costs eligible for federal funds matching.

In the following sections, we provide more detail about each phase of CNSI's framework. In addition, CNSI provides a more comprehensive discussion of several early essential activities, including the critical ICD-10 Assessment in Section 4 of this document.

2.1.1 ICD-10 PROGRAM STRATEGY / PLANNING

During this phase, the architecture for the high-level management approach is defined. Activities during the first phase include:

- Defining the governance model
- Defining the program management approach
- Establishing the Project Management Office (PMO)
- Defining assessment teams
- Defining program management templates
- Understanding high-level benefits of ICD-10

2.1.2 ICD-10 ASSESSMENT

The ICD-10 Assessment is the foundation for program planning and requirements definition. This is the second phase of the framework. Activities during this phase include:

- Conducting a thorough business assessment using the MITA framework
- Developing a business process impact scoring model by risk (severity and probability of impact)
- Conducting assessment interviews
- Developing training plans
- Developing ICD-10 awareness content and deployment plans

2.1.3 ICD-10 REMEDIATION STRATEGY/ROADMAP

The ICD-10 Remediation Strategy/Roadmap further defines the strategic approach not only for the program, but for each identified essential business process. Activities of this phase include:

- Developing business process impact model reports from business process flows
- Defining a remediation approach by major business process area. Refer to Section 2.2 for additional details on this topic

- Defining training requirements by defined training levels for each affected area of the SMA'S organization
- Developing a high-level ICD-10 requirement document
- Detailing short-term and long-term goals that will be tracked during ongoing operations

2.1.4 ICD-10 PLANNING / DETAILED BUDGETING

ICD-10 Planning and Detailed Budgeting build upon resource requirements gathered from previous phases, primarily the assessment. This phase further refines timelines, project plans and resource commitments. Activities of this phase include:

- Developing detailed planning and budgeting by work breakdown structure (WBS)
- Developing detailed resource plans by implementation work breakdown structure
- Developing and baselining the detailed project plan
- Preparing and submitting the Advance Planning Document (APD) for implementation

2.1.5 ICD-10 IMPLEMENTATION AND TESTING

The ICD-10 Implementation and Testing phase of the framework is the start of system design and business process redesign activities. The System Development Life Cycle (SDLC) for the SMA's information technology systems and related technologies begins during this phase. This includes development of detailed business requirements. The development or redefinition of new business processes within the organization begins during this phase. Outputs and activities of this phase include:

- Redefining and documenting business processes and updated medical policy
- Developing technical specifications for technology impacts
- Developing the overall business and technology test strategy
- Developing or modifying use cases
- Developing software programming changes
- Testing system modifications and impacts

2.1.6 ONGOING OPERATIONS / BENEFITS REALIZATION

Ongoing operations and benefits realization include any activities required to maintain an ICD-10 compliant operation and obtaining measurable benefits. Outputs and activities of this ongoing phase include:

- Decentralizing ICD-10 program governance resources
- Monitoring operational compliance

- Tracking short and long-term strategic goals
- Measuring the benefits of ICD-10 compliance

2.2 COMPLIANCE APPROACHES / REMEDIATION STRATEGIES

Beginning 2008, the payer community has attempted to solve the ICD-10 remediation problem using many approaches. Those approaches included:

- **Direct Implementation:** This strategy is to consume, adjudicate, clinically approve, pay and report off ICD-10 codes. This affects all business processes using ICD codes
- **Crosswalk Approach:** This strategy attempts to translate an ICD-9 code into one or many ICD-10 codes depending upon relevant usage of the code for a particular meaningful use
- **Partial Direct Implementation:** This strategy lies between direct implementation and the crosswalk approach

In the early stages of the remediation effort, the majority of health care industry participants preferred the crosswalk approach believing that it would limit the changes to payer business functions. Since then payer, provider, and clinical communities have departed from that approach for several reasons. In CNSI’s experience with the private sector, the factors driving this were:

- Reporting and analytics inconsistencies
- Reimbursement inconsistencies
- Clinical interpretation (medical policy and management) discrepancies
- Payer and claims adjudication edits and audit discrepancies

Table 1 is a high-level summary of the differences between three overall approaches presented earlier by major business process. It is important to understand the strategic decision making should be approached by choosing one of the three approaches for each horizontal business process.

Table 1. Comparison of Payer Strategies

Major Business Process	Direct Implementation	Partial Direct Implementation	Crosswalk Approach
Accept Claim	ICD-10	ICD-9 or ICD-10	ICD-10 > ICD-9
Adjudicate Claim	ICD-10	ICD-9 or ICD-10	ICD-9
Reimburse	ICD-10	ICD-9 or ICD-10	ICD-9

Major Business Process	Direct Implementation	Partial Direct Implementation	Crosswalk Approach
Reporting/Analytics	ICD-10	ICD-9 or ICD-10	ICD-9
Medical Policy	ICD-10	ICD-9 or ICD-10	ICD-9

To determine the best strategy for a SMA, a full ICD-10 assessment must be performed. The primary factor governing the selection of any remediation strategy is the SMA’s ability to consume and use ICD-10 data. This is dependent on the overall maturity of the SMA’s business processes and the flexibility and maturity of the technologies supporting the affected business processes. The SMA must conduct a MITA self assessment^{iv} to establish their level of organization maturity within the MITA framework. To leverage ICD-10 benefits in years directly after the compliance date SMAs should:

- Use a modern, MITA-centric, Medicaid Management Information System (MMIS) such as eCAMS, CNSI’s CMS certified MMIS. For more details on eCAMS please visit CNSI’s website WWW.CNS-INC.COM
- Achieve a MITA maturity level of 4 or 5 allowing the SMA to take advantage of Health Information Technology (HIT) and Health Information Exchange (HIE) benefits

SECTION 3 – ICD-10 BENEFITS

3.1 GENERAL STRATEGIC BENEFITS

The real value associated with the adaptation & implementation of an ICD-10 transition will occur after October 1, 2013, often within several years. The magnitude of the coding changes coupled with the uncertainty of provider coding behavior present a risk in terms of pricing errors and management of care. However there are operational benefits (short-term) and quality of care benefits (long-term) associated with a well planned ICD-10 transition, these are described below.

3.1.1 SHORT TERM BENEFITS

Short-term opportunities are defined as value created as a result of the transition that may not be sustainable in the long term however; they contribute to the decision making of the remediation approach. Short term opportunities include operational enhancements, cost avoidance, streamlined processes, and provider outreach to facilitate a more accurate measurement of quality of care, and education and Fraud and Abuse programs^v. For SMAs, streamlined processes will include less manual operational processes such as fewer prior authorizations and fewer attachments requests. For many SMAs cost avoidance would include any financial action detrimental to the Medicaid program, such as inappropriate payments.

3.1.2 LONG-TERM STRATEGIC BENEFITS

Long term opportunities are defined as value created as a result of the transition that will persist over time. Long term opportunities should be the main focus for any government (Medicare or Medicaid) payer plan. Although the benefits and eligibility rules for entitlement programs may change it is likely that the programs themselves will not be available for several years after the 2013 implementation date. Long-term opportunities include total medical cost reduction and pricing strategies, clinical programs, informatics / analytics / predictive modeling and direction to improve quality of care.

3.2 MITA ALIGNMENT BENEFITS

CNSI's ICD-10 Implementation of the ICD-10 codes will improve the effectiveness and efficiency of SMAs medical management processes in several MITA business areas. The list below includes the eight different MITA Business Areas and their corresponding ICD-10 usage and opportunities. The descriptions provided in this section are general and non-specific. Most of the information provided was extracted from the State Medicaid ICD-10 Impact Analysis Report^{vi}. The usage and opportunities may or may not be applicable to all SMAs.

- Member Management:
 - ICD-10 Code Usage - Member Management Processes determine eligibility, enroll members, disenroll members, manage member information, and manage member

- appeals and grievances. ICD-10-CM codes are used to determine eligibility qualifications and verify disenrollment from the State
- ICD-10 Opportunities - Improve the ability to understand and respond to the health of the population, and improve the appeal process since ICD-10 codes are specific, allowing for appeals to contain refined information on medical condition and needs
 - Operations Management
 - ICD-10 Code Usage - The Operations Management business processes use ICD-10 codes for processing claims, service authorization, and capitation pricing, to check recipient lifetime limits, verify clinical appropriateness of services, and suspend encounters
 - ICD-10 Opportunities - Improve the accuracy and efficiency of claim payments and processing due to greater coding specificity. Enhance and improve accuracy of data analytics and reporting (i.e., utilization and reimbursement trending). Improve health plan and provider relationships by reducing disputes as a result of the more granular coding and payment structure. Fewer prior authorizations and less paper documentation
 - Program Management
 - ICD-10 Code Usage - Program Management activities include adding new codes, adjusting rates associated with codes, and adding and updating existing rates, benefits, provider information, and drug formulary information
 - ICD-10 Opportunities - Improve specificity for beneficiary programs better meeting the needs of the population. Improve clarity in benefit packages. Increase accuracy in accounting processes utilizing decision support system. Ability to improve processes to identify fraud and abuse. Flexibility to improve quality of care utilizing healthcare data analytics, including cost of care and medical management. Increase accuracy in benefit packages due to greater granularity of ICD-10
 - Contractor Management
 - ICD-10 Code Usage - Contractor Management business area processes include Requests for Proposals (RFP), reviews of content against an RFP, designates contractor/vendor, handles the protest process, negotiates contracts, and notifies parties
 - ICD-10 Opportunities - Decrease grievances and protests due to greater accuracy, fairness, and understanding of RFP and contract requirements. Additional opportunities may accrue where contracts are dependent on ICD-10 codes

- **Provider Management**
 - ICD-10 Code Usage – For Provider Management activities including provider enrollment and disenrollment: As providers enroll in Medicaid with specialty/taxonomy, they are limited to treatment of the diseases that fit within their specialty
 - ICD-10 Opportunities - Decrease the number of appeals and grievances due to greater accuracy in record keeping and claims processing. The increased detail in ICD-10-CM offers the ability to provide contracting more appropriate to the level of severity and condition. Improved program integrity through more granular coding to limit treatments. As some providers limit their own practice (e.g., OB/GYN providers quit delivering babies), those diagnoses could be removed from the provider's profile without removing other treatments. As a result of a provider disenrolling, members may be notified and/or reassigned to a provider with similar allowed services
- **Care Management**
 - ICD-10 Code Usage – The Care Management activities include management of the Medicaid Health Population, establishing a Medicaid case, managing a Medicaid case and management of the registry
 - ICD-10 Opportunities - Increase in control in the monitoring of population health and target populations that receive benefits. Increase in control in deciphering provisions of care management services for members
- **Program Integrity Management**
 - ICD-10 Code Usage – Program Integrity Management activities include identification of candidate case and management of candidate cases. Program integrity management uses State-specific criteria to identify target populations.
 - ICD-10 Opportunities – Cases can be filtered by ICD-10 codes, for more precise examination, monitoring and follow-up
- **Business Relationship Management**
 - ICD-10 Code Usage – Business relationship management activities include the cycle of establishing a business relationship to termination of a business relationship. This complete cycle may use ICD codes; however there are no obvious opportunities within this business process MITA area

SECTION 4 – EARLY ESSENTIAL ICD-10 PROGRAM ACTIVITIES

There are two critical activities that are essential to the overall success of the SMAs ICD-10 remediation program. These two foundation activities are:

- Conduct an ICD-10 Assessment to determine where functional roles, business processes, and technologies are impacted directly or indirectly
- Choose a translation strategy and associated supporting tools to gain the benefits of early prioritization of policy and process remediation

CNSI presents further details on both of these activities in the following sections.

4.1 ASSESSMENT OVERVIEW

The Medicaid ICD-10 assessment is perhaps the most important phase of the CNSI ICD-10 Strategic Framework. The level of detail and quality of knowledge gained through the assessment will be leveraged substantially to define a strategic direction, early high-level requirements and detailed process improvements and business requirements. A thorough assessment will position the SMA to define their requirements clearly, resulting in a successful implementation, and fully realized benefits. The Medicaid ICD-10 Assessment should be done by a dedicated sub-team with knowledge of the Medicaid payer system, ICD-10 changes, benefits, and risks.

Unlike the HIPAA 5010 compliance effort, ICD-10 requires both business process changes and technology changes. Best practices suggest that assessments should be performed by qualified business partners who bring substantial ICD-10 knowledge and business process re-design experience to the table.

Key objectives of a SMA ICD-10 assessment should include:

- Identify the impacts of ICD -10 mandates on organizational structure and business operations including functional departments
- Assess the impact to existing enterprise systems
- Identify impacts across key business and trading partners and associated risks. The Trading Partner Matrix and the Application Vendor Partner Tracking worksheets should be substantially complete prior to the assessment
- Identify implementation options and approaches for ICD-10 transformation
- Understand risk and value of alternative options to the enterprise, customers and partners
- Ensure ICD-10 aligns with Medicaid and HIT strategic goals

Figure 2 below is a detailed representation of Phase 2 components of the CNSI ICD -10 program framework described in Section 2 (Figure 1). Figure 2 shows detailed activities included in Phase 2 of the effort.

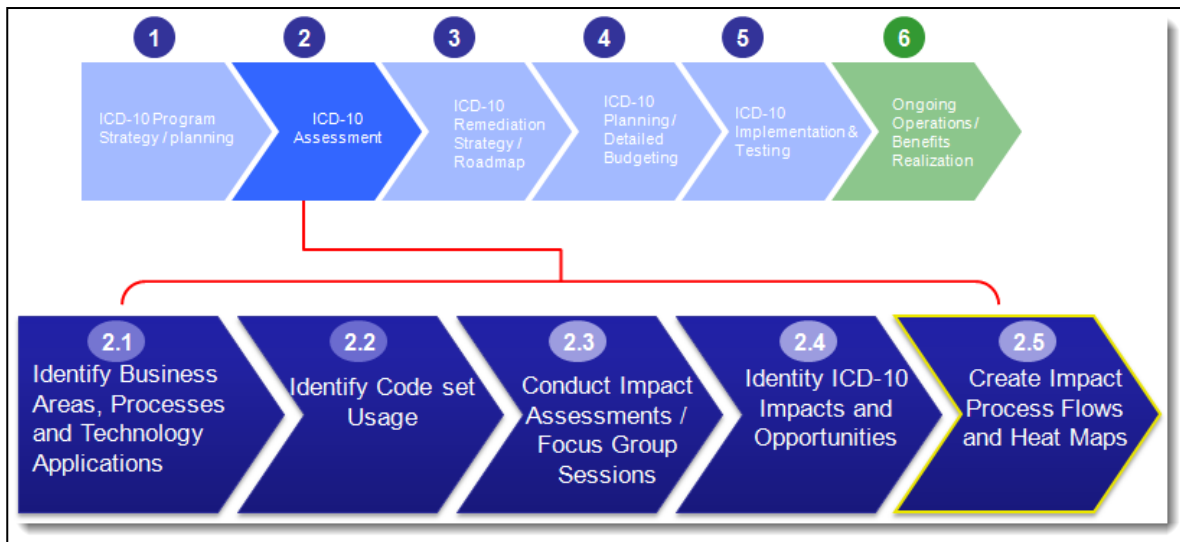


Figure 2. ICD-10 Assessment Methodology

4.2 TRANSLATION STRATEGY

Translation Strategy refers to the approach taken to translate the clinical meaning of an ICD-9 code to the equivalent clinically-related ICD-10 code(s). Since a one-to-one mapping does not exist between all codes, a complete translation/transformation will have to occur. Depending upon the strategic approach for each business area the methods for code translation will differ. Pricing of claims may use a different approach than the payment of services. Actuarial analytics and management reports may require a different approach than the clinical medical policy business areas. Before any approach can be devised for the functional areas, all areas should undergo a comprehensive ICD-9 assessment as discussed in Section 4 – Early Essential ICD-10 Program Activities. While it is ideal to conduct the steps in the framework in sequential order, the reality of the compliance date may necessitate creative approaches and fast-tracking the program effort.

Regardless of the strategic approach chosen for any area of the Medicaid payer process, four activities should be considered. Three of the activities are highly recommended and one is optional.

1. Highly Recommended: Identification of where ICD-9 codes are currently used within the claims adjudication system:
 - a. Dependant groups or collection of codes are included in the identification of where ICD-9 codes are located

- b. Identification of algorithm and/or ranges of ICD-9 codes and the basis for their use within the claims adjudication system
 - c. Identification and location of where the truth of source of the data containing the code resides (typically within the business functional area, on an unrelated departmental system)
 2. Highly Recommended: For implementation efficiency there will be a need to “stratify” historical claims into various groups such as:
 - a. Highest use ICD codes by dollar value
 - b. Highest use ICD codes by number of transactions
 3. Highly Recommended: Development of medical policy workflow/audit trail functionality. The transformation from ICD-9 to ICD-10 is unlike the normal code update cycles; nearly all codes will have to be reviewed for clinical meaning and clinical equivalence. Prior to ICD-10, the annual ICD-9 code update included between 25 – 100 codes to be analyzed by medical management/care management professionals. For ICD-10, all 70,000 codes must be reviewed. Based on CNSI’s experience, detailed review of all 70,000 codes may not be possible in the time remaining prior to the compliance date. Therefore, it is essential that the SMA prioritize the medical review and approval process targeting code ranges based on the stratification listed in number 2 above.
 - a. Includes workflow approval and routing of medical policy updates
 - b. Includes data warehousing of medical policy revisions in a centralized database
 4. Optional: Clinical interpretations of ICD-9 codes to ICD-10 codes will be needed to supplement the medical professionals’ clinical knowledge of diagnosis and procedure codes and their related clinical interpretations.

To manage the translation/transformation process, technology products may be leveraged to aid the clinical/medical professional and medical policy review processes. The following section discusses the general types of technology products that a SMA may want to consider for analysis.

4.2.1 CNSI TECHNOLOGY PRODUCTS OVERVIEW

In general, the technology products designed to support ICD-10 translation are short-term tactical aids (sometimes referred to as “disposable” technology); and have recently been developed to support the ICD-10 federal mandate. There are many solutions in the marketplace for ICD-10 remediation. The core functionality of these tools can be simplified into four categories which correspond to the activities that should be considered as listed in the preceding section:

- **ICD-9 code reference locators** – ICD-9 codes are used throughout many claim adjudication systems. SMAs will need a structured approach to understand fully where ICD-9 codes are referenced throughout the system and how they are grouped, bundled, and leveraged for claims processing (Number 1 in Section 4.2). This is typically accomplished by using web and code crawler software. This step is essential to ICD-10 compliance. CNSI’s proprietary tool, iCRL can perform this function.
- **Claim Analysis toolsets** - Most products in the marketplace selling ICD-10 solutions have some version of a historical claim analysis tool (Number 2 in Section 4.2). This is a claim extract (one or two years) that stratifies claim data by volume and value for various user defined variables. This analysis is not required for ICD-10 translation, but is necessary for efficient tasking of medical policy translation (start on the highest volume/reimbursement areas first). CNSI’s proprietary tool, iAnalyze, works seamlessly with eCAMS SMA claims adjudication systems and can also easily integrate with other MMIS systems.
- **Care Management/Medical Policy Workflow and Audit toolsets** - Fewer ICD-10 solutions in the marketplace today contain medial management, care management, medical policy workflow and audit functionality (Number 3 in Section 4.2). This is the most important functionality for ICD -10 translation effort. The number of codes, medical policy approvals and decisions is vast. This activity is on the critical path of most ICD-10 translation initiatives. The best tools available in the market place are integrated within the medical policy management system, or an additional feature to the claims adjudication system; this reduces the opportunity for the technology to be disposable (limited shelf life technology). CNSI’s proprietary tool, iPolicy, is perhaps the most valuable product of the CNSI ICD-10 suite. iPolicy, unlike other technology tools in this space has an unlimited shelf life and is designed to be either a standalone product or an integrated solution within the eCAMS solution.
- **Clinical interpretations toolsets** - The number of codes that will need to be analyzed by medical professionals is vast; furthermore the areas of medical domain in both codes sets (9 and 10) cover many areas of the medical profession of which resident expertise is not available. To address this need of clinical interpretations between ICD-9 and ICD-10 concepts few tools contain verifiable, board-certified medical input into the translation effort (Number 4 in Section 4.2). This clinical input provides valuable medical insight into medical domains that would otherwise need to be learned by SMA clinicians.

Many firms in the technology and clinical data space provide a tool or suite of tools that provide robust functionality in one or more of the categories listed above. In several cases, the technology is specific to the software platform it supports.

CNSI recommends that SMA use caution in reviewing and selecting technology to support the effort. Emphasis should be firmly placed on satisfying the specific needs of SMA which are:

- Understand where the codes are used
- Understand how the codes are used
- Apply appropriate prioritization to the translation efforts for medical policy and auditing

A well thought out strategy should also consider tools that both serve its needs in becoming compliant and provide benefits beyond achieving ICD-10 compliance.

SECTION 5 – SUMMARY

This paper provides a logical approach to manage and organize SMAs ICD-10 program initiatives. The CNSI ICD-10 framework begins with an initial strategy and continues through ongoing operations / benefits realization. Each phase of the framework is described in broad terms and in detail where applicable given the current state of progress for many SMAs. Utilization of the Framework, methodologies and technologies should be used together is possible to maximize the value to the SMA. The document is based on CNSI’s public sector experience, industry best practices, ICD-10 specific training, and CNSI’s in-depth knowledge of working with SMAs on their ICD-10 compliance efforts.

ⁱ Medicaid Implementation Handbook, ICD-10, Noblis, January 2011

ⁱⁱ ICD-10 Medicaid Implementation Assistance Handbook (CMS)

ⁱⁱⁱ Centers for Medicare and Medicaid Services, Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement (MITS-11-01-V1.0), Version 1.0 April 2011.

^{iv} CNSI, A Proposed Vendor-Neutral Environment to Support the Automation of MITA State Self-Assessments (SS-As), A CNSI White Paper, August 2006.

^v Deloitte Consulting, AHIP 5010 / ICD10 Training Series F101: Unlocking the Value of ICD-10; Developing Architectural Solutions, ICD-10 Value Opportunities.

^{vi} State Medicaid ICD-10 Impact Analysis Report, CMS Version 2.0, Noblis, August 6, 2010