Status of the Implementation of ICD-10

SL 2015-241, Section 12A.6.(b)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

by

North Carolina Department of Health and Human Services

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INTRODUCTION

STATUS OF THE IMPLEMENTATION OF ICD-10

On October 1, 2015, NCTracks successfully implemented the International Classification of Diseases, 10th Revision (ICD-10), Clinical Modification (CM) and ICD-10 Procedure Coding System (PCS). Since implementation, DHHS has been analyzing data and monitoring the impact of ICD-10 across the provider communities. The analysis indicates there are no significant variations in claims payment levels attributable to ICD-10 implementation and the following downstream effects validate these findings:

- All claim types have been submitted and successfully processed
- ICD-10 claims adjudication percentages are meeting or exceeding historical benchmarks
- All check-write cycles with ICD-10 claims have processed with no issues
- All the calls are tracked in production as the project has been closed as of December 31, 2015.
- Five provider associations confirmed they are not experiencing any ICD-10 issues
- Providers have not requested hardship advances due to ICD-10 implementation

SESSION LAW 2015-241, SECTION 12A.6.(b)

Beginning on November 15, 2015, and monthly thereafter, the Department of Health and Human Services (Department) shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the status of the implementation of ICD-10. The Department shall continue to submit the report by the 15th of each month until three consecutive months have passed in which the Department did not issue any hardship advances and until the new Department of Information Technology (DIT), created by this act, can assume this function. Thereafter, the Department or DIT, as appropriate, shall submit this report upon request of the Joint Legislative Oversight Committee on Health and Human Services. The report shall include all of the following items:

(1) An analysis of claims payments prior to the implementation compared to post implementation by major provider category that identifies any variations in claims payment levels.

(2) For variations attributable to the implementation of ICD-10, the report shall include corrective actions and communications that resulted from the identification of the variation.

(3) An update on hardship advances made to providers for payment issues arising for the implementation of ICD-10 that specifies the total amount advanced and the total amount recovered to date listed by provider.

BACKGROUND

a) Overview of ICD-10:

ICD-10 is a revision of the ICD-9 system used to code diagnoses, symptoms, and procedures recorded in hospitals and physician practices. The ICD-10 revisions provide more precise codes and have more than 68,000 diagnostic codes, compared to the 13,000 found in ICD-9. The revision also includes twice as many categories and is more specific in identifying treatment. ICD-10 provides a number of advantages such as:

- Improved claims payment accuracy and efficiency
- Improved accuracy of quality measures
- Reduced attachments to explain the patient's condition
- Detailed clinical information in a single ICD-10 procedure code
- Improved tracking of public health measures and population epidemiologic research
- Better identification of risk and severity
- Expanded flexibility for coding new diseases and medical procedures in the future

b) Background on ICD-10 Implementation:

The Centers for Medicare and Medicaid Services (CMS) published the original rule on January 16, 2009 - HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS. The rule was revised and a final rule was posted August 24, 2012 that requires all HIPAA covered entities to adopt the ICD-10 code sets which replaces the ICD-9 code sets with a compliance date of October 1, 2015 - Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets. ICD-10 diagnosis codes are used in all U.S. health care settings. ICD-10 procedure codes are used in inpatient hospital settings only.

c) Implementation Strategy:

The design adopted for NCTracks is dual compliant and able to process ICD-9 and ICD-10 codes based on Dates of Service (DOS) and Dates of Discharge. Any claims submitted with a DOS prior to the implementation deadline of October 1, 2015 will be processed using an ICD-9 code. Any claims submitted with a DOS on or after the implementation deadline will be processed using the ICD-10 code.

REPORT REQUIREMENTS

SECTION 12A.6(b) (1): An analysis of claims payments prior to the implementation compared to post implementation by major provider category that identifies any variations in claims payment levels.

Analysis Results: The analysis performed compares September 2015 ICD-9 claims payment with ICD-10 claims payment in October 2015 through February 2016 as per the criteria listed in Appendix A. The average claim payment for post-implementation compared to pre-implementation yielded an average decrease in the amount paid per claim for ICD-10 claims by $15.35. This equates to a lower average variance of 6% for ICD-10 claims payments compared with the data reported in January and February 2016.

The table provided in Appendix A lists the major provider categories and their associated variance. There are a number of variables that could impact the variances shown and the discussion below provides explanations. At this point, the Department has no reason to believe the variances are as a result of the ICD-10 implementation, however the Department will continue to proactively monitor the data as it is received.

Variance Explanations: The following bullets provide some explanation for the variances by major provider category. See Appendix A to find the provider category variance.

- *Inpatient*: The Diagnosis Related Grouper (DRG) software was updated effective October 1, 2015 as mandated by CMS. This update occurs annually and impacts the weights and rates used to price inpatient claims. For example, a claim for extreme immaturity or respiratory distress syndrome -neonate DRG code 790 in DRG version 32 paid $29,635.91 and the same claim in DRG version 33 now pays $29,020.10.

- *Medicare Crossover*: The changes implemented on March 1, 2015 for processing Medicare crossover claims for services rendered to Qualified Medicare Beneficiaries (QMBs) were not aligned with CMS guidance for State Medicaid plans. This misalignment resulted in over payment of some claims. On October 1, 2015 DMA applied the "lesser of" logic change for services covered by both Medicare and Medicaid for QMB recipients per CMS guidance. As a result of this change there will be an overall decrease in the average claim payment.

- *All Categories*: The types of claims submitted for a particular provider category, service and recipient could be vastly different from one month to the next.

To further validate these variance explanations, a detailed analysis was performed comparing the previous nine months of ICD-9 average payment per claim with the ICD-10 average payment per claim and found the variance to be relatively consistent. See Appendix B to find the associated data.

Professional and Outpatient claims pricing are not impacted by the ICD-10 implementation or the DRG software update. The fee schedule for these claims are based on the Healthcare Common Procedure Coding System and the Current Procedural Terminology codes in NCTracks which did not change. Appendix C provides a sample comparison of randomly selected Professional and Outpatient claim lines paid for the same service in ICD-9 and ICD-10. The results show that ICD-9 claims are paid exactly the same as ICD-10 claims. Thus, for Professional and Outpatient claims, the variance percentage is low and may be attributed to the differences in the types of claims submitted by these providers.

ICD-10 implementation impacted the edit criteria used to determine eligibility for claims payment. To more accurately understand the impact of this change, an analysis was performed comparing claims denial rates for ICD-9 and ICD-10 claims. The denials were valid and were as a result of common provider submission errors. To date, the analysis continues to shows that ICD-10 denial rates are consistent with ICD-9 denial rates. This indicates that the ICD-10 eligibility criteria implemented in NCTracks is functioning consistent with ICD-9 criteria. See Appendix D to find the comparison chart.

SECTION 12A.6.(b) (2): For variations attributable to the implementation of ICD-10, the report shall include corrective actions and communications that resulted from the identification of the variation.

Corrective action: There have been no variances attributable to the implementation of ICD-10. Additionally, there have been no variances reported by the providers and no corrective actions and/or communications addressing payment variances as a result of ICD-10. The Department will continue to monitor and analyze the data as it is received and will proactively manage any corrective actions needed.

Preventive actions taken: Claims payment variance analysis was done as part of User Acceptance and Provider/Trading Partner Testing. There were no variances reported that required any preventive actions to be taken.

Communications: Communications were sent regularly to the providers during pre-implementation and post-implementation regarding payment variances as a result of the DRG software annual update as mandated by CMS. Also, communications regarding the provider submission errors were sent via email, website updates, conferences and help desk services.

SECTION 12A.6.(b) (3): An update on hardship advances made to providers for payment issues arising for the implementation of ICD-10 that specifies the total amount advanced and the total amount recovered to date listed by provider.

To date there have been no hardship requests from the providers due to ICD-10 implementation.

CONCLUSION

NCTracks implementation of ICD-10 continues to be a success. ICD-10 claims submitted by providers are being processed and paid within historical performance benchmarks. The Department continues to proactively collaborate with the provider community to analyze and resolve any issues they experience as a result of ICD-10. Feedback from the provider community has been positive since implementation. Analysis of claims payment levels indicates that on average, ICD-10 claim payments are 8% less than ICD-9 claim payments The analysis also points out that there are a number of variables that impact claims payment levels, however none have been determined to be attributed to ICD-10 implementation. More data over time must be collected and analyzed to definitively validate these findings. The Department will remain diligent in collecting, monitoring and analyzing NCTracks ICD-10 performance metrics and will proactively resolve any issues that arise.

APPENDIX A

ICD-9 vs ICD-10 claims payment comparison summary report by provider category

Criteria: This table includes ICD-9 claims with dates of service in September 2015 and paid in September 2015 compared to ICD-10 claims with dates of service in October 2015 through February 2016 and paid in October 2015 through February 2016 respectively.

	ICD-9 vs ICD-10 claims payment comparison report							
	ICD-9 claims payment in September 2015 (Date of Service in September 2015)			ICD-10 claims Payment in October 2015 - February 2016 (Date of Service in Oct 2015 - Feb 2016)				
Claim Type	ICD-9 claim count	ICD-9 paid amount in Sep'15	ICD-9 average amount per claim	ICD-10 claim count	ICD-10 paid amount in Oct'15 - Feb'16	ICD-10 average amount per claim	ICD-9 variance	ICD-9 variance %
PROFESSIONAL	734,357	$62,670,153.16	$85.34	2,333,923	$202,910,474.36	$86.94	$1.60	1.87%
DENTAL	183,971	$29,791,383.35	$161.94	678,011	$108,529,884.15	$160.07	-$1.86	-1.15%
PERSONAL CARE SERVICES	134,878	$35,503,296.04	$263.23	502,858	$117,729,402.24	$234.12	-$29.10	-11.06%
OUTPATIENT	149,139	$40,748,738.74	$273.23	477,756	$129,536,143.16	$271.13	-$2.09	-0.77%
THERAPY SERVICES	72,109	$6,818,951.04	$94.56	247,753	$22,490,751.93	$90.78	-$3.79	-4.00%
INDEPENDENT LABORATORY / XRAY	67,876	$5,662,449.09	$83.42	228,999	$13,173,643.21	$57.53	-$25.90	-31.04%
NURSING HOME	50,694	$72,175,525.24	$1,423.75	170,235	$102,496,205.63	$602.09	-$821.66	-57.71%
RURAL HLTH CLINIC / FEDERALLY QUALIFIED HLTH CNTR	36,285	$3,324,443.69	$91.62	136,611	$49,006,187.17	$358.73	$267.11	291.54%
DURABLE MEDICAL EQUIPMENT	42,359	$8,976,821.96	$211.92	122,028	$26,273,357.30	$215.31	$3.38	1.60%
OPTICAL	19,745	$490,572.90	$24.85	85,456	$4,079,816.00	$47.74	$22.90	92.15%
MEDICARE PART B CROSSOVER (PROFESSIONAL)	79,549	$1,002,127.60	$12.60	167,823	$3,989,908.06	$23.77	$11.18	88.72%
HEALTH DEPARTMENTS	18,969	$1,583,315.76	$83.47	60,068	$4,204,723.02	$70.00	-$13.47	-16.14%
INSTITUTIONAL AMBULANCE	12,373	$1,614,659.52	$130.50	25,528	$3,637,355.82	$142.48	$11.99	9.19%
CHILDRENS DEVELOPMENTAL SERVICES AGENCIES	8,033	$587,540.47	$73.14	27,531	$35,002,398.46	$1,271.38	$1,198.24	$16.38
HOME HEALTH	6,810	$961,299.65	$141.16	22,687	$2,630,546.53	$115.95	-$25.21	-17.86%
INPATIENT	7,761	$26,162,590.89	$3,371.03	21,881	$51,687,380.27	$2,362.20	-$1,008.83	-29.93%
LOCAL EDUCATION AGENCIES	3,461	$161,574.33	$46.68	12,819	$537,598.10	$41.94	-$4.75	-10.17%
PRIVATE DUTY NURSING	2,713	$4,811,425.50	$1,773.47	9,773	$10,882,945.90	$1,113.57	-$659.90	-37.21%
MEDICARE PART B CROSSOVER UB (OUTPATIENT)	9,238	$507,460.95	$54.93	14,791	$4,623,217.30	$312.57	$257.64	469.01%
HOME INFUSION THERAPY	492	$428,399.46	$870.73	2,145	$883,471.69	$411.87	-$458.86	-52.70%
MENTAL HEALTH	208	$456,021.22	$2,192.41	1,011	$1,417,376.93	$1,401.96	-$790.45	-36.05%
INDEP DIAG TESTING FACILITY / PORTABLE XRAY	221	$20,608.02	$93.25	593	$55,694.81	$93.92	$0.67	0.72%
HEARING AID	75	$11,943.31	$159.24	333	$350,873.52	$1,053.67	$894.43	561.67%
MEDICARE PART A CROSSOVER (INPATIENT)	658	$3,915.90	$5.95	1,166	$12,366.70	$10.61	$4.65	78.22%
HOSPICE	436	$1,377,415.34	$3,159.21	133	$206,669.97	$1,553.91	-$1,605.30	-50.81%
Total	**1,642,410**	**$305,852,633.13**		**5,351,912**	**$896,348,392.23**			
Average ICD-9 paid amount per claim in September 2015	**$186.22**							
Average ICD-9 paid amount per claim from January - September 2015	**$182.83**							
Average ICD-10 paid amount per claim in October 2015 - February 2016	**$167.48**							

Notes:

Denied and suspended claims are not included for this analysis.

February data is based on paid claim as of 02/24/2016.

APPENDIX B

Average Payment per claim comparison report

Average Payment per Claim : ICD-9 vs ICD-10	
Claim Category	**Average Payment per claim**
ICD-9 average payment per claim (Jan'15 - Sep' 15)	$182.83
ICD-10 average payment per claim (OCT'15 - Feb'16)	$167.48
Variance	$15.35

APPENDIX C

Sample claim line level payment comparison report

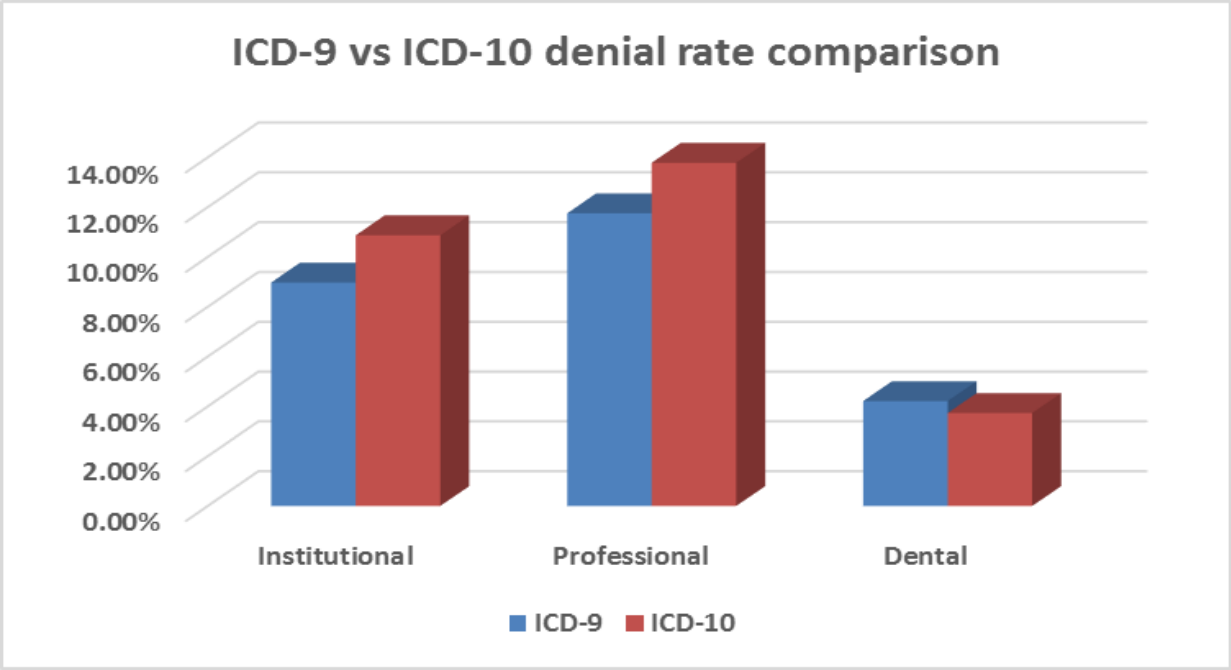
Criteria: The ICD-9 claim lines with the same procedure code and base rate in September 2015 compared with the equivalent ICD-10 claim line in February 2016.

		Sample claim detail payment comparison for February 2016			
Provider	**Procedure code**	**Procedure description**	**Base rate**	**ICD-10 claim line paid amount**	**ICD-9 claim line paid amount**
Professional	74329	ENDOSCOPIC CATH PANCREATIC DUCT SYS FLUR	$29.29	$29.29	$29.29
Professional	80335	ANTIDEPRESSANT TRICYCLIC 1/2	$20.09	$20.09	$20.09
Professional	93662	INTRACARDIAC ECHOCARDIOGRAPHY DURING THE	$125.01	$125.01	$125.01
Rural health clinic/Federally Qualified Health center	76830	ULTRASOUND, TRANSVAGINAL	$66.87	$66.87	$66.87
Rural health clinic/Federally Qualified Health center	87880	INFECTIOUS AGENT DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION	$14.57	$14.57	$14.57
Rural health clinic/Federally Qualified Health center	83036	HEMOGLOBIN; GLYCOSYLATED (A1C)	$12.34	$12.34	$12.34
Health Departments	86592	SYPHILIS, PRECIPITATION OR FLOCCULATION TESTS	$5.42	$5.42	$5.42
Health Departments	J1885	KETOROLAC TROMETHAMINE, PER 15 MG (TORAD	$1.28	$1.28	$1.28
Outpatient	85008	BLOOD COUNT; BLOOD SMEAR, MICROSCOPIC EX	$4.29	$4.29	$4.29
Outpatient	85705	THROMBOPLASTIN INHIBITION; TISSUE	$12.00	$12.00	$12.00
Outpatient	86702	ANTIBODY; HIV-2	$14.65	$14.65	$14.65

APPENDIX D

ICD-9 vs ICD-10 denial rate comparison report

Criteria: The ICD-9 denied claims in September 2015 compared with ICD-10 denied claims in February 2016



Note:

The regular provider submission errors which were common prior to ICD-10 implementation are contributing to the slight increase in claim denial rate. No major ICD-10 issues have been identified as contributing to the denial rate. The top denials includes invalid recipient, duplicate claim, referring provider invalid for Carolina Access recipient, TPL suspect.