The Centers for Medicare & Medicaid Services (CMS) ICD-10 Planning AHIMA Report

Project Scope

In September 2008, CMS concluded a one year project with the American Health Information Management Association (AHIMA) to identify and assess the business processes, systems and operations under CMS' direct responsibility that would potentially be impacted by a transition to the ICD-10 code set. The analysis outlined below includes information gathered from CMS components from late 2007 to early 2008, therefore the impacts and risks surrounding new legislation or initiatives, such as the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 were not assessed for this report.

The AHIMA project was the first of several efforts that will be undertaken to prepare CMS for the transition to ICD-10. The second phase of planning has been initiated, and is expected to build on AHIMA's findings, and move CMS closer to an implementation plan within the coming year. This next phase will also include the impacts and risk surrounding new legislation and initiatives not accounted for in the AHIMA analysis.

We published an initial summary of AHIMA's executive report shortly after the project's conclusion, and at that time indicated that we would post more details of the report following our internal review and analysis. The attached document is that more detailed report of the AHIMA study findings. This second phase of the report provides a more extensive chronicling of CMS business processes that may be impacted by the transition to ICD-10. Although both the project and report were intended to be solely CMS-focused, the agency is committed to sharing the report (subject to internal clearance), to provide relevant insights for ICD-10 planning and implementation activities. We will continue to share information regarding ICD-10 implementation as it becomes available.

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PROJECT INTRODUCTION

Purpose of ICD-10 Planning Project

The Secretary of Health and Human Services (HHS) adopted the International Classification of Diseases, 9th Edition (ICD-9-CM) code set as the Health Insurance Portability and Accountability Act (HIPAA) standards in the Transactions and Code Sets Rule, which was published on August 17, 2000. ICD-9-CM became the standard for reporting diagnoses in all treatment settings and for reporting procedures in inpatient hospital settings. The Centers for Medicare & Medicaid Services (CMS) is positioned to take a lead role in implementing the next version of this code set, the International Classification of Diseases, 10th Edition (ICD-10), nationwide. This would mean replacing the ICD-9-CM code set with ICD-10-CM for diagnoses and ICD-10 Procedure Coding System (PCS) for inpatient hospital procedures. ICD-10-CM is maintained by the National Center for Health Statistics (NCHS) in the Centers for Disease Control and Prevention (CDC). ICD-10-PCS is maintained by CMS, and both ICD-10-CM and ICD-10-PCS are publicly available coding systems.

On September 28, 2007 the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) contracted with the American Health Information Management Association (AHIMA) for ICD-10-CM and ICD-10-PCS planning and implementation assistance. CMS gave responsibility for the project to the Office of E-Health Standards and Services (OESS). AHIMA located the project in their Foundation of Research and Education (FORE). The overall objective was to determine the impact that implementing the ICD-10 code sets will have on CMS systems, policies, processes, operations, and components. Deliverables included a comprehensive document that can be used to develop a detailed project and implementation plan, as well as educational materials.

The data collected through the methodology outlined below are included in this report. The data represent the impacts of ICD-10 on affected business functional areas, operations, policies, processes, and systems. The report findings include an assessment of the Nature of the Impacts, Implementation Risks, Interdependencies, Cost Estimates and Recommendations.

Project Methodology

This section describes the methodology used to conduct an analysis of the processes, systems and functions of CMS as they relate to the usage of ICD-9 codes. Throughout the project, the assessment team worked closely with CMS to inform CMS stakeholders of the ICD-10 transition, collect relevant data and develop the impact assessment. The FORE impact assessment methodology described below was developed in collaboration with CMS as a means of identifying a successful process to conduct the research in the current environment. Our methodology was designed to be considerate of the time required of resources to assist in the processes. Therefore, the following steps were employed to ensure a successful assessment:

i. Project Orientation Meetings – The initial phase familiarized components about the project goals, timeframes and outlined the requirements of the components in terms of resources necessary to complete the project tasks. These kick-off meetings allowed components to voice concerns and ask questions prior to the data collection phase.

ii. Determine Team Assignments – To best handle the project workload, the FORE project team was split into four separate teams (Red/Green/Yellow/Blue). Each colored team consisted of a team lead, coding specialist and a business analyst. In addition, all teams shared a process modeler and a cost estimator. The entire effort was led by a project manager. The teams were each assigned specific CMS components to work with based on an initial assessment of workload, systems and impact in an effort to balance the workload for each team. The component assignments enabled the teams to complete the task of reaching into all of the organizational corners and identify all potential impacts throughout CMS. A list of these team assignments is provided in Appendix A; Project Team Resource Assignments. As the project evolved, changes were made to the assignments as needed to redistribute workload. Understanding the complexity of CMS and its cross component processes, the structure of the project mandated that the teams share knowledge by bringing the larger group together on a weekly basis. This knowledge sharing continued throughout the project. Once team assignments were identified the data collection phase began.

iii. Data Collection – To prepare for these interviews, each team conducted exhaustive research and review of documentation, business models, websites, online manuals and other documents provided by OESS and the various stakeholders. Twice weekly each team met so that all team members could share the knowledge gained. Each team was then responsible for sharing their knowledge with the entire project team. The process of sharing knowledge amongst the project team was important for the identification and classification of business process flow throughout the agency. OESS was responsible for working with the components to identify the most appropriate CMS staff for interviews. They then scheduled all interviews which were conducted with a

combination of in-person and conference call formats. Data collection interviews were broken into two types, overview and detailed, and are described below.

a. Overview Interview - The goal of each overview interview was to give the components an orientation to the project, collect a high level description of the work (processes/functions) their group/division performed relating to ICD-9 usage, the systems they utilized or owned, how ICD-9 codes were currently used, risks of the transition to ICD-10 and to identify the names of subject matter experts and system owners/maintainers to take part in future detailed interviews. The overview interviews were conducted at the group level for all CMS offices and centers, however some offices and centers chose to decline participation in the project. A list of components that declined participations is included in the Process Details section of this report.

   The goal of the Overview Interviews was to have a group representative along with a representative from each division within the group participate in the interview. Once the interview was completed and the relevant information gathered, a high level summary report was produced for each group. The summary report was organized by the processes that group owned, managed or interacted with where ICD-9 codes were utilized. Each identified process was assessed to ascertain the potential impact of the transition to ICD-10 on that group/division, any associated risks and estimated costs. The FORE team preliminarily ranked the processes by the impact of the transition from ICD-9 to ICD-10 based on the data collected. The processes listed by ranking were used to scheduled additional interviews in an effort to gather more detailed data regarding the process. The detailed interview process is described below. Processes determined to have minor to no impact related to the implementation of ICD-10 were not scheduled for a detailed interview.

b. Detailed Interview – To prepare for the detailed interviews, the FORE teams were assigned specific processes from the ranking created as a result of the overview interviews. This was done to enable the teams to follow a process across organizational boundaries and not be limited by the original component assignments. The detailed interviews were set up by OESS based on contacts identified during the overview interviews and were process focused. Interviews were conducted with at least one FORE team member onsite with the remaining team members joining by conference line. These interviews included CMS subject matter experts who worked on a specific process regardless of component affiliation. Systems owners and maintainers for systems utilized by the process were included. The goal of the detailed interviews was to collect the steps in the process, determine impact

points for the process and in the systems used, identify how ICD codes were used, identify exchanges, identify risks and collect cost estimates for the transition. A list of questions (Appendix D) and process maps were developed to assist during the interviews and keep the group focused,. After completing the interview, the process maps were updated and a process summary report was created to document the findings.

iv. Develop Process Summary Reports - The process summary reports consist of the following sections:

- Process Overview – An overview of the process including process owners and components that use the process.

- Process Detailed Findings – This section includes discussion about the steps in the process including exchanges (inputs/outputs) with other processes, components involved, systems involved and their source of information, and impact. It also includes the process diagram to illustrate the steps in the process that use ICD-9 codes, the system(s) used by the process and whether the system(s) uses ICD-9 codes.

- Process Risks – Risks to the process or systems of transitioning to ICD-10 and risk level ranking

These reports were reviewed by CMS business and systems owners for accuracy. The reports can be found in Process Details Section of this report.

v. Development of Initial Findings Report – The Initial Findings Report includes all the detail summary reports as well as the executive briefings, project introduction and appendices. The development of this report is outlined in detail below.

Assessment Ranking Levels

The data collected throughout the project was evaluated for relevance to the CMS ICD-10 implementation by each team. The area of effects were categorized by, impact, risk and costs based on the definitions outlined below. The ranking definitions were developed by the project team which included experts in the areas of coding, reimbursement, systems, business processes and cost estimation. Although ranking levels such as this are relatively subjective, the team utilized their expert judgment and extensive experience to determine the most appropriate categorization for each area identified. The traditional project management ranking colors of Red, Orange, Yellow and Green were used to add a visual effect to the ranking levels. This ties all of the reports together in the Findings Matrix within the Executive Summary Section of this report. The ranking levels corresponded to colors as follows: High – Red; Medium – Orange; Modest – Yellow; Minor – Green. For the purpose of this report, the highest level of impact was deemed as the process impact level, no matter if the ranking related to an impact, risk or cost. The ranking level definitions are outlined below in Tables 1, 2 and 3.

Table 1. Impact Ranking Level Definitions

Rank Level	Rank Definition
Minor Impact (Green)	Potential for little or no measurable impact to cost (and/or schedule) of the project.
Modest Impact (Yellow)	Potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.
Medium Impact (Orange)	Potential for noticeable cost (and/or schedule) increases to the project.
High Impact (Red)	Potential for significant cost (and/or schedule) increases to the project.

Table 2. Risk Ranking Level Definitions

Rank Level	Rank Definition
Minor Risk Impact (Green)	Potential for minimal or routine modifications to the process
Modest Risk Impact (Yellow)	Potential for small and intermittent modifications to the process
Medium Risk Impact (Orange)	Potential to noticeably disrupt work
High Risk Impact (Red)	Potential to significantly disrupt work

Table 3. Cost Ranking Level Definitions

Rank Level	Rank Definition
Minor Cost Impact (Green)	Cost will be under $100,000
Modest Cost Impact (Yellow)	Cost will be between $100,000 to $1,000,000
Medium Cost Impact (Orange)	Cost will be between $1,000,000 to $10,000,000
High Cost Impact (Red)	Cost will be over $10,000,000

Process Report Organization

The Process Details Reports includes the following sections:

- Process Summary Ranking Table
- Process Overview
- Related Processes
- Process Description
- Impact
- Process Diagram

Process Summary Ranking Table

The beginning of each report includes a table that displays the overall process ranking in the first column, an example is shown below. The subsequent columns display all Groups and/or Divisions included in the process along with their corresponding ranking. The overall ranking displayed for the process is the highest ranking impact, risk or cost for the entire process. Each Group and/or Division listed is shown with the highest rank for that Group or Division. As you read the text, you may notice that a Group or Division is ranked multiple times throughout the report if they are included in multiple steps in the process. The ranking table displays the highest rank, of all the listed impacts within the Process Summary report.

The example below is the Process Summary Ranking Table for the Appeals Process. This process includes two main Offices or Centers (Center for Beneficiary Choices (CBC) and The Office of Information Services (OIS)) as well as Groups and Divisions within each Office and Center. The CBC includes the Medicare Enrollment & Appeals Group, ranked as a Medium impact in the color of Orange as well as the Division of Appeals Operation s and the Division of Appeals Policy, ranked at Minor in the color of Green. The OIS includes the Business Applications and Management Group, ranked as Modest in the color Yellow. Because the highest rank within the three centers and offices listed below is Medium, the Appeals Process is ranked as Medium in the color of Orange.

Table 4. Process Summary Report ICD-10 Implementation Impact Ranking, Appeals Process

Appeals Process Rank: Medium[1] or Orange Level	Center for Beneficiary Choices (CBC)/ Medicare Enrollment & Appeals Group (MEAG)/ Division of Appeals Operations (DAO): Medium or Orange Level	Center for Beneficiary Choices (CBC)/ Medicare Enrollment & Appeals Group (MEAG)/ Division of Appeals Policy (DAP): Minor[2] or Green Level	The Office of Information Services (OIS)/ Business Applications and Management Group (BAMG): Modest[3] or Yellow Level

[1] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.
[2] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.
[3] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

Process Overview

The Process Overview summarizes the functions of the process, including the components involved in the process and a high level summary of the information collected about the process. The general functions and purpose of the process as well as the divisions/groups identified as being a part of the process are discussed in this area as well. The overview also identifies the systems utilized in the process and the major areas of impact outlined in the summary document.

Related Processes

Additional processes within CMS that are related to the identified process are described in the Related Process section. This section briefly describes the inputs and outputs to the related process including where ICD codes enter or leave the process, as well as the systems containing ICD Codes.

Process Description

The Process Description is the narrative description of the entire process describing each step in the process. The descriptions include where the steps originate, the inputs and outputs from other processes, the format of data entering the step including an explanation of the context of the processes. The context of the process includes the roles of the various business and process owners and managers involved in each step in the process, as well as identify the resources that maintain the systems, other stakeholders and relevant contractors. In addition, the context describes the systems are involved, including information within the software system that is relevant to ICD-9 codes and the resources that utilize the data exchanged from the system. The importance of each step, including the data exchanged within the step is also described.

Impact

The impact section of the Process Summary Report outlines the impacts of each sub-process or step within the process and displays the appropriate ranking level. Each process includes multiple steps and sub-processes with an identified ranking. The entire process ranking is reviewed and the highest rankings associated to each Office/Center, Group or Division is identified.

PROCESS DETAILS

Claims Processing
Part A/B Claims (Institutional)
FISS and CWF
Impact Rank: High

Table 5. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Office of Information Services(OIS): High[4] or Red Level	Office Information Services(OIS)/ Business Applications Management Group (BAMG) ranking: High
(Red Level)	(Red Level)

Process Overview

Fiscal Intermediary Standard System (FISS) is the shared system used by fee-for-service (FFS) claims contractors, Medicare Administrative Contractors (MACs), to process institutional Medicare Part A claims and outpatient claims submitted under Part B. After submission of a claim into FISS, the claim processes through a pre-defined claim path assigned by the type of bill (TOB). FISS, in conjunction with the Medicare Code Editor (MCE) and the Integrated Outpatient Code Editor (I/OCE), performs consistency and administrative editing including International Classification of Disease (ICD) field values submitted on the claim. The MCE and IOCE are code editors that also perform all functions that require specific reference to ICD-9-CM diagnosis codes. FISS validates the accuracy of the code and performs CMS specific ICD diagnosis editing. When providers submit codes in the wrong format, FISS will require modifications to the claim to continue processing.

Expert Claims Processing System (ECPS) is an artificial intelligence module that automatically works within FISS to make decisions and resolves edits during claims processing. ECPS events are designed by contractors to enforce Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) as well as other editing requirements. In ECPS, events are sets of criteria and corresponding actions that the system applies to incoming claims as well as claims during processing. When event criteria match the criteria on a claim, ECPS takes action automatically to resolve claim errors and/or warnings.

Prepayment medical or non-medical review occurs when FISS edits suspend a claim before the claim is paid. Prepayment edits are designed by CMS or the MAC to prevent payment for non-covered and/or not medically necessary services. Prepayment edits are established, modified and evaluated for effectiveness on an ongoing basis.

Once the claim is adjudicated the process continues and impacts all downstream users. Adjudication of the claim will result in many downstream users such as, but not limited to: National Claims History (NCH), Provider Statistical and Reimbursement (PS&R), Coordination of Benefits Contractor (COBC), and the Common Working File (CWF).

[4] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.

The CWF contains information about all Medicare beneficiaries. The standard shared systems interface with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

CMS also issues a quarterly release of program specification changes which are created by various CMS division components utilizing the Change Management Process. Any FISS specification changes are communicated by CMS components utilizing the Change Request/Change Management Process via Electronic Change Information Management Portal (eCHIMP) system. The standard systems change process is coordinated by the Medicare Contractor Management Group (MCMG) Division of Changes and Operations Management (DCOM).

The accuracy of the instructional specification changes which contain International Classification of Disease (ICD) codes are of ***high*** impact and critical to provider billing for beneficiary services and the Office of Information Systems (OIS) standard system updates which are utilized by the FFS contractors for claims processing.

For a given fiscal year, the quarterly release schedule includes standard systems and claims processing specifications including ICD codes is as follows:

- First Quarterly Release — On or about October 1,
- Second Quarterly Release — On or about January 1,
- Third Quarterly Release — On or about April 1, and,
- Fourth Quarterly Release — On or about July 1,

The following FISS online screens have been identified to contain ICD diagnosis/procedure codes and will be required to change for ICD10:

- Medicare Secondary Payer (MSP) Insurer,
- End Stage Renal Disease (ESRD) Remarks,
- CWF Attachment,
- Therapy Attachment,
- Plan of Care Attachment,
- Medicare Severity –Diagnosis Related Grouper (MS-DRG) Pricer,
- Roster Bill,
- Medical Policy,
- International Classification of Disease,
- Limit of Liability,
- Hook Selection,
- ESRD Healthcare Common Procedural Coding (HCPC) Parm Limitation,
- ESRD Revenue Parm Limitation, and,
- Mass Adjustment Selection,
- Expert Claims Processing System (ECPS),

- Claim Inquiry Screen

The following Direct Data Entry (DDE) online screens have been identified to contain ICD diagnosis/procedure codes and will be required to change for ICD-10:

- MS-DRG/Pricer Inquiry,
- ICD Diagnosis/Procedure Code Inquiry,
- Home Health Attachment, and,
- Therapy Attachment.

Related Processes

The Centers for Medicare Management (CMM) components develop and implement new payment policy based on Federal mandate, CMS initiative or costs savings, which may include ICD codes which impact the standard system specifications.

Provider Billing Group (PBG) communicates the required operational changes which are developed based on the needs of the policy updates via the Change Request Management Process by publishing a change request for implementation. FISS interfaces/interacts with other CMS software applications and editors such as: Medicare Severity-Diagnosis Related (MS-DRG) Groupers; Code Editors; Pricers; and Fee Schedules. Not all of the applications contain ICD codes. For example, the fee schedules *do not* contain ICD codes. However, some edit tables and Pricers do contain ICD codes, such as the Clinical Lab Edit Table.

The Provider Communications Group (PCG), in coordination with the CR author, develops and publishes various media content for use in FFS provider and contractor educational materials based on payment policy specification changes which may include ICD coding instructional changes.

Part A and B crossover utilization is when the Host receives a Part A bill, CWF automatically checks the information in the record against the beneficiary's history files for both Part A and Part B utilization. If there is a conflict (or "crossover") of services, CWF will generate an A/B crossover error code. These are returned on the reply Trailer 13 and will contain only one A/B crossover error code.

The Medicare Integrity Operations Process Report includes Pre-Payment Medical Review Process which is the action of medical review staff which performs either a routine or complex reviews of a non-adjudicated claim.

The Develop and Utilize Assessment Tools Process Summary Report explains the Claims Submission process and is interrelated to the Institutional Claims (Part A, Part B) process. The output of the Development and Utilize Assessment Tools – Claims Submission process is the creation of provider claims which are submitted for claims processing.

The Medicare Secondary Payer (MSP) process objectives are identification of beneficiaries' claims which CMS may have erroneously paid as the primary insurer and to recover funds mistakenly paid by CMS. The MSP process is primarily a post payment activity, but it also features a pre-payment process with front-end edits that are generated in the presence of MSP auxiliary records at CWF.

The Manage CMS System Repositories and their Data Outputs process provides a detailed review of the CMS system repositories and the data files built from those repositories to provide an understanding of the data flow, the system usage and the ICD-10 transition impact.

Direct Data Entry (DDE) connectivity allows the provider, clearinghouse or MAC user to do the following:

- Enter UB04 claims,
- Correct electronic claims that were submitted by batch mode (EDI Transfer),
- Correct claims originally submitted on paper,
- Track all claims through the processing system,
- View the check number, date and amount of the last 3 payments,
- View a variety of files for inquiry purposes, i.e. ICD diagnosis codes, revenue codes, and ANSI reason codes and
- Access the Common Working File (CWF) via HIQA (Health Insurance Query Access) to find information on beneficiary entitlement, eligibility, and other insurance.

Table 6. FISS Claims Processing Illustration below reflects the pertinent use by each fee-for-service (FFS) payment policy, type of claim processed by FISS, associated claims processing applications, and any associated dependent patient assessment databases external to the claims process used for the FFS payment policy development. Relevant areas associated with or without ICD codes are noted in the illustration.

Table 6. FISS Claims Processing Illustration

FFS Payment Policy	Medicare Part A	Medicare Part B	MCE	I/OCE (Diagnosis code field 1-5 edit)	Fee Schedule	Pricer Software	MS-DRG Grouper (ICD Codes)	Case-mix Grouper (ICD codes)	Patient Assessment Instrument
Acute Inpatient	√	√(12x)	√ (11x)	√ (TOB 12x)		√	√		
Ambulance		√			√(except CAH based)				
Clinical Laboratory		√		√	√				
ESRD(renal Dialysis Facility)		√		√ (TOB 72x)		√		Case mix composite rate - no grouper	
Home Health	√	√		√(TOB 34x) add TOB 32x,33x		√(ICD-Codes)		√(Integrated into OASIS software & HAVEN) HIPPS codes	√OASIS(HAVEN)

Hospice	√			√ **(TOB 81x, 82x)**	√	√**(No ICD Codes)**				√ **Notice of Election (NOE) ICD codes goes to CWF**
Hospital Outpatient		√		√**13x**	√**(preventives)**	√**OPPS Pricer**				
Long Term Care Hospital	√	√**(12x)**	√**11x**	√**(12x)**			√			
Physician		√		√	√					
Psychiatric (inpatient)	√	√**(12x)**	√**11x**	√**(12x)**		√**(ICD codes)**	√			
Rehabilitation (inpatient)	√	√**(12x)**	√**11x**	√**(12x)**				√ **CMG 2.20 integrated into IRVEN**	√ **IRF-PAI (detemines HIPPS codes) IRVEN**	
ORF(OPT)/CORF		√	√	√ **TOB 74x,75x**	√					

Skilled Nursing Facility	√	√	**√21x**	**√ (TOB 22x, 23x)**		**√ (ICD codes, HIV add-on code)**	**√ RUG-III Integrated into RAVEN**	**√ MDS (RAVEN)**
CAHs	√	√	**√11x**	**√85x**	√	√		
FQHCs		√		**√73x**				
RHCs		√		**√71x**				
CMHCs		√		**√76x**		**√(OPPS Pricer)**		

Process Description

1. OIS/BAMG arranges for the X12 837 standards Health Insurance Portability and Accountability Act of 1996 (HIPAA) Guide, hereafter referred to as Technical Reports 3 (TR3), and the Medicare Companion Guide to be available to the MAC via download

   Impact: No Impact.

2. The MAC receives confirmation of an active rule set after test setups have been run from OIS/BAMG.

   Impact: No Impact.

The MAC sends the editor updates and the partner updates to the EDI Front end for compliance.

Impact: No Impact.

3. The MAC reaches an agreement with the Hospital or Provider for use in Institutional Part A and Part B Claims Process.

   Impact: No Impact.

4. There are three ways in which an institutional Part A and Part B Claim is entered for processing:

   a. Through the front end EDI in the X12 837 packet,
   b. Scanned In (OCR), and,
   c. Through Direct Data Entry.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

   Risk: There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in a claim denial, overpayment or underpayment to occur during processing.

5. The Hospital or Provider utilizes the Claim Calculator help Information for the Help Modules which allows access to FISS documentation when entering an institutional Part A and Part B Claim. The FISS data store is utilized during this activity.

   Impact: No impact.

6. The Hospital or Provider sends an Institutional paper form (UB04) to the MAC where the claim is received and controlled. The Part A/Part B institutional claim is scanned into the application system.

   Impact: There is ***no impact*** to the scanning process, yet the paper forms contain ICD codes.

   Risk: There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in claim denial, overpayment, or underpayment to occur during processing.

7. Due to the fact that this is a non-EDI transaction; the MAC creates a Part A or Part B Application Record. This process contains ICD codes.

   Impact: The process impact is high due to ICD-10 character and field length requirements needed to the standard system.

8. The institutional non-EDI transaction is converted to a UB04 Institutional Claim Flat File. This process contains ICD codes. This is the point where the non-EDI transactions and those that come through the EDI front come together.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

9. When a Medicare Part B outpatient claim is sent through the front end EDI, it is mapped via the X12 837 packet to the application file. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

10. The institutional Part A or Part B claim is converted into the UB04 Institutional Claims Flat File Format This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

11. The MAC/FISS/MedATran receives the claim and verifies compliance to the TR3 Rules. These HIPAA edits may also occur in the EDI front-end. This process contains ICD codes. MedATran will be disabled after 5010 implementation.

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

12. In the next activity, the verified institutional Part A or Part B claim is sent to the FISS/ECPS/Super Ops/Medical Review Policy where an audit may occur on the related

ICD diagnosis codes and suspends the claims from the claims process that are deemed medically unlikely to occur. These claims are sent to the Medicare Integrity Operations via the Pre-Payment Medical Review Process.

Please refer to the *Medicare Integrity Operations Process Summary Report perform Pre-Payment Medical Review Process* for more detailed information.

Impact: ECPS or Medical Review Policy will automatically move claims to the Additional Documentation/Development Request (ADR) status/location, and makes decisions on claims without human intervention. ECPS may pay, deny or suspend to send the claims to Medical Review for further investigation. The impact is ***high*** for claims that require the ADR which may include an assigned reason code which may contain ICD code or condition specific narrative. The documentation and edits with the ADR reason code narratives associated with ICD codes and DDE screens would need to alter for ICD-10 character and field length requirements needed to the standard system.

Risk: There is a ***high*** risk associated with MACs establishing and defining condition specific criteria for ECPS edits using the wrong ICD diagnosis code(s) not set by CMS. This could result in un-necessary denial, suspension, overpayment or underpayment of a claim.

13. The institutional claim is then verified for claims consistency with National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). The Medicare Code Editor (MCE) module or the Integrated Outpatient Code Editor (I/OCE), which is an editor and a grouper, is verifying ICD codes for the relevant inpatient or outpatient edits. The edits utilized depend on the type of the bill claim (inpatient or outpatient). The claim leaves this step with indicators for action e.g. denial, acceptance, discounts etc. This process contains ICD codes.

    Impact: The process impact is ***high*** or less as stated due to the following:

    - There is a ***high*** impact to the FISS claims process since the claims process includes ICD diagnosis codes based upon date of service (DOS) on the claim. The ongoing use of ICD-9 will be required by the standard systems for an extended period of time. Not only must the systems accommodate the receipt of claims for more than a year after a service was rendered, the systems must accommodate processing of claim adjustments for those dates of service for several years beyond implementation of ICD-10.

    - There is a ***high*** impact to FISS longitudinal data since ICD data is included in claims and there are linkages by beneficiary data across years and files. Although a crosswalk between ICD-9 and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Also, as the implementation of ICD-10 is expected to be accomplished

on a fiscal year basis, nine months of data will be in the ICD-9 classification format and 3 months of that year will be in the ICD-10 classification.

- CMS implements formal coverage policies on a national scale through NCDs that describe the conditions under which Medicare coverage for specific items and services is granted, limited, or excluded. The Office of Clinical Standards and Quality (OCSQ) oversees and is responsible for national quality initiatives that include ICD codes. The OCSQ Coverage and Analysis Group (CAG) works in collaboration with CMM policy development components to create the national coverage determinations. NCDs are binding on all MACs and they may not have local policies that conflict with a NCD. The MACs may develop local policies in areas where an NCD is silent. There is a need to duplicate NCD file edit changes within FISS to include ICD-10 codes based on date of service. There is a ***minor***[5] impact to the claims process for addition of the new ICD-10 NCDs to FISS. The process is controlled during implementation of the NCDs in the FISS standard systems under comprehensive control and testing during the CMS Change Management Control/Change Request (CR) process.

Risk:

- The Medicare Fee-For-Service contractors will have to create new ICD-10 LCDs to reflect the coverage language in the existing ICD-9 LCDs. There is a ***high*** risk of misinterpretations and coding errors will occur if existing LCDs are created exclusively by the MACs utilizing manual coding crosswalks. If the same newly created LCDs with errors are translated into the MAC contractor's FISS edits it would result in the denial, underpayment, or overpayment of claims.

- CMS components will create new ICD-10 NCDs to reflect the coverage language from the existing ICD-9 NCDs. There is a ***minor*** risk to the claims process that coding errors in NCDs would occur due to collaboration between CAG and CMM Division of Acute Care (DAC) coding expertise during NCD development. Also, risk is lessened by the implementation of the NCDs in the FISS standard systems under the comprehensive control and testing during the CMS Change Management Control/Change Request (CR) process.

14. The verified Part A and Part B claims take different paths in order to be priced correctly. The different routes are based on code groups that determine the type of bill. There are ICD codes in some of the pricing modules. The relevant Pricer modules are noted below.

[5] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.

Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

15. A verified Part A Claim for Acute Inpatient, LTCH, and Psychiatric Inpatient is sent to the next activity where the Part A Claim uses the MSDRG Grouper to determine the diagnosis of the related group of claims. The MSDRG Grouper Module determines diagnosis, demographic and discharge status. The claim is sent on for pricing. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

16. The Part A Claim with the DRG attached is Priced depending on the type of bill (TOB). Two of these Pricers contain ICD Codes which are noted below. The priced Part A Claim is then sent to CWF. The CWF steps are discussed between process steps 20 - 27. The three Pricing Modules used are:

    1. IPPS Pricer (contains ICD Codes),
    2. LTCH Pricer, and,
    3. Psychiatric Inpatient Pricer (contains ICD Codes).

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

17. The Part A Claim for Hospice is passed through for pricing and a Notice of Election (NOE) it is created. When a subsequent claim is processed through CWF, CWF ensures a benefit period created from the NOE exists before continuing with processing for payment. The claim is priced depending on the TOB. Inpatient Rehabilitation and Skilled Nursing are immediately passed through for pricing and do not utilize the NOE. Only one of these Pricers contains ICD Codes which is noted below. The priced claim is then sent to CWF. The CWF steps are discussed between process steps 20 – 27. The three Pricing Modules used are:

    1. Hospice Pricer,
    2. Inpatient Rehabilitation Pricer, and,
    3. Skilled Nursing Facility Pricer (contains ICD Codes).

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

18. The Part B Claim for Ambulance, Ambulatory Surgery Center, ESRD and Home Health (or RAP) Hospital Outpatient and is immediately passed through for pricing. The claim is priced depending on the TOB. A Fee Schedule is used to price the Ambulance claims. The others use pricing modules. The priced claim is then sent to CWF. The CWF steps are discussed between process steps 20 – 27.

1. Ambulance Fee Schedule,
2. ESRD Pricer Module,
3. Home Health Pricer Module, and,
4. OPPS Pricer Module.

Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system

19. The Priced Claims are then sent to CWF for eligibility determination and payment authorization. The whole claim is not sent to CWF. CWF host communicated with the relevant contractors. Trailers are used to communicate with the contractor as to why the contractor is receiving this record. CWF sends the Adjudicated Claim within 3 to 5 days. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

20. CWF receives the priced claim from FISS and performs a consistency edit to ensure it is in the correct format. Because CWF is not HIPAA compliant, it only accepts one format. CWF determines eligibility and utilization. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.
    - The CWF edits are run simultaneously against the ICD-9 codes in CWF. By January 2009, the CWF business owner will have a generalized equivalent mapping for ICD-10 in order to mitigate impact.

21. CWF sends the adjudicated claim to the Archiving Process – Common Working File Medicare Quality Assurance (CWFMQA).

    Please refer to the *Manage CMS System Repositories and Data Outputs Archiving Process Summary Report* and illustration for more detailed information on this process. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

22. CWF produces an advisory file that with the Medicare amount payable in association with an occurrence of a Beneficiary with Other Insurance (BOI) record. The advisory file contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

23. The Medicare Payable Advisory File, with CWF trailers, including trailer 29, are sent from CWF to FISS. FISS will use this information to select the claims where there is a secondary payer to crossover to the Coordination of Benefits Contractor (COBC). This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

24. The beneficiary history and profile information is sent to the EDB. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

25. FISS sends a Coordination of Benefits (COB) flat file containing claims for beneficiaries with other insurance for inclusion in the Coordination of Benefits Agreement Crossover process. This process contains ICD codes.

    Please refer to the Coordination of Benefits Agreement Crossover process for more detailed information on this process.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

26. CWF sends payment approval directly to FISS. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

27. FISS accepts the payment approval and forwards to the accounting process for Part B Payment.

    Impact: ***No Impact.***

28. In the next activity, FISS receives the Part B claims payment.

    Impact: ***No Impact.***

29. FISS splits the electronic fund transfer (EFT) payments from the paper payments.

    Impact: ***No Impact.***

30. Payments for EDI recipients are sent via an EFT Payment Flat File in an EFT record to the EDI back end process.

    Impact: ***No Impact.***

31. The payments for non-EDI transactions are then captured in a Paper Check File. This file is sent to the MAC for payments and paper checks are then distributed to the provider.

    Impact: ***No Impact.***

32. After Eligibility Determination and payment authorization is determined, CWF sends the claims payment outcome advice to FISS.

    Impact: ***No Impact***.

33. FISS receives the claim payment outcome advice and formal claim acceptance or denial advice is sent, by paper Standard Paper Remit (SPR), back to the Provider.

    Impact: ***Minor.***

    - Programmers may require training to understand the changes to the tables\reports for ICD-10 codes.

34. An explanation of benefits is sent through a Medicare Summary Notice to the Beneficiary. This process contains ICD Codes.

    Impact: ***Minor.***

    - Programmers may require training to understand the ICD-10 code changes to the tables\reports.

Process Risk Assessment

The current process for updating the FISS ICD diagnosis code set is a manual communication via the CR process to the MAC contractors. The ***high***[6] risk associated with the manual updating of the ICD-10 Diagnosis code set files during implementation could be eliminated with CMS requiring the automation of the ICD-10 load process to allow for greater ease and flexibility of installing upgrades to the code set.

There is a ***high*** risk to the FISS claims process for claim denial or error due to the need to simultaneously process both ICD-9 and ICD-10 code sets after implementation of ICD-10. Currently FISS processes claims based upon date of discharge for inpatient claims and date of service on a Part B claim; the ongoing use of ICD-9 will be required by the FISS standard systems for an extended period of time. Not only must the systems accommodate the receipt of

[6] A High or Red Level Process will stop, work or payment will cease at time of transition

claims for more than a year after a service was rendered, the systems must accommodate processing of adjustments for those dates of service for several years. Therefore, dual processing of ICD-9 and ICD-10 must be planned and accommodated to continue to a date determined appropriate by CMS.

The Medicare Administrative Contractors (MACs) will have to create new ICD-10 LCDs to reflect the coverage language in the existing MAC ICD-9 LCDs. There is a ***high*** risk of misinterpretations and coding errors will occur if existing LCDs are created exclusively by the MACs utilizing manual coding crosswalks. If the same newly created LCDs with errors are translated into the MAC contractor's FISS ECPS or Medical Review policy edits it would result in the denial, underpayment, or overpayment of claims.

There is a ***high*** risk associated with MACs establishing and defining condition specific criteria for ECPS edits using the wrong ICD diagnosis code(s) not set by CMS. This could result in un-necessary denial, suspension, overpayment or underpayment of a claim.

There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in a claim denial, overpayment or underpayment to occur during claim processing.

Claims Processing
Part B (Non-Institutional)
MCS and CWF
Impact Rank: High

Table 6. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Office of Information Services(OIS): High[7] **(Red Level)**	Office Information Services(OIS)/ Business Applications Management Group (BAMG) ranking: High (Red Level)

Process Overview

The Multi-Carrier System (MCS) is a mainframe system managed by the CMS Office of Information Systems (OIS) Business Application Management Group (BAMG) in which Electronic Data System (EDS) is the standard system maintainer. The fee-for-service (FFS) claims processors, the Medicare Administrative Contractors (MACs), use MCS to process Medicare Part B non-institutional claims. These claims include physician care, durable medical equipment (non-supplier), and other outpatient services nationwide.

Non-institutional Part B claims can be entered, corrected, adjusted, or canceled within MCS, as well as inquiries are completed for status of claims**,** for additional development requests, or for eligibility and various codes can be processed. It is important to note that MCS only requires the utilization of the International Classification of Disease (ICD) diagnosis file, and will not be impacted by the transition of ICD-10-PCS for procedures which is used on Part A inpatient claims.

The Common Working File (CWF) contains information about all Medicare beneficiaries. The MCS shared system interfaces with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

CMS also issues a quarterly release of program specification changes which are created by various CMS division components utilizing the Change Management Process. Any MCS standard systems software specification changes are communicated by CMS components utilizing the Change Request/Change Management Process via Electronic Change Information Management Portal (eCHIMP) system. The standard systems change process is coordinated by Medicare Contractor Management Group (MCMG) Division of Changes and Operations Management (DCOM).
The accuracy of the instructional specification changes which contain ICD codes are of ***high*** impact and critical to provider billing for beneficiary services and the Office of

[7] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.

Information Systems (OIS) standard system updates which are utilized by the FFS contractors for claims processing.
For a given fiscal year, the quarterly release schedule includes standard systems and claims processing specifications including ICD codes is as follows:

- First Quarterly Release — On or about October 1,
- Second Quarterly Release — On or about January 1,
- Third Quarterly Release — On or about April 1, and,
- Fourth Quarterly Release — On or about July 1.

The following areas within MCS will require updating to accommodate ICD-10:

1. ICD Diagnosis code file set,
2. MCS user screen configuration,
3. Online screen changes to include all non-claim specific screens that house ICD diagnosis codes.
4. Multi-Carrier System Desktop Tool (MCSDT) screen changes to include all non-claim specific screens that house ICD diagnosis codes.
5. Reporting changes - includes all non-claim specific reports that house ICD diagnosis codes.
6. Pre-pass edit changes,
7. SCF Auto-adjudication changes,
8. Front end processing,
9. Medical review policy processing,
10. Field changes to the Laboratory NCD Edit Software,
11. Clinical Lab Edit Table within the NCD Edit Software,
    - The Clinical Laboratory NCD Edit Table is an ICD diagnosis-to-procedure code edit table used by all Medicare contractors to process Medicare claims. The purpose of the edit table is to ensure that the Medicare claims subject to one of the negotiated laboratory NCDs are processed uniformly throughout the nation. Every ICD diagnosis code falls into one of the three possible lists used in the edit module for the negotiated laboratory NCDs.

The implementation of ICD-10 is likely to have a ***high*** impact on the MCS claims process due to the following reasons:

1. The required changes to accommodate the ICD-10 character and field length within the MCS standard claims processing system.
2. The need to dual process claims utilizing both ICD diagnosis code sets based on the date of service (DOS).
3. The need to update the annual MCS ICD diagnosis code file set.
4. The need to duplicate Local Coverage Determination (LCD) file edit changes to include ICD-10 codes based on the DOS.

Related Processes

The Centers for Medicare Management (CMM) components develop new policy based on

Federal mandate, CMS initiative or costs savings, which may include ICD codes which impact the MCS system specifications.

Table 7. MCS Claims Processing Illustration below reflects the pertinent use by each fee-for-service (FFS) payment policy, type of claim processed by MCS, associated claims processing applications, and any associated dependent patient assessment databases external to the claims process used for the FFS payment policy development. Relevant areas associated with or without ICD codes are noted in the illustration.

Table 7. MCS Claims Processing Summary Illustration

FFS Payment Policy	Medicare Part A	Medicare Part B	I/OCE (Diagnosis code field 1-5 edit)	Fee Schedule	Pricer Software	MS-DRG Grouper (ICD Codes)	Case-mix Grouper (ICD codes)	Pati Asses Instru
Ambulance		√		√(except CAH based)				
Ambulatory Surgery Center		√						
Clinical Laboratory		√	√	√				
Physician		√	√	√				

Provider Billing Group (PBG) communicates the required specification changes during the develop and implement payment policy process to meet the needs of the policy change via the Change Request Management Process (CR) to OIS/Business Applications Management Group (BAMG) for implementation.

Provider Communications Group (PCG) develops and publishes various media content for use in FFS provider and contractor educational materials based on MCS specification changes which may include coding instructional changes.

MCS interfaces/interacts with other CMS software applications such as fee schedules, which do *not* contain ICD codes. However, any edit tables do contain ICD codes, for example the Clinical Lab Edit Table.

CMS requires and schedules standard system quarterly updates that each Medicare contractor must load into their claim processing system. These standard quarterly updates take place each January, April, July, and October.

Part A and B crossover utilization is when the Host receives a Part A bill, CWF automatically checks the information in the record against the beneficiary's history files for both Part A and Part B utilization. If there is a conflict (or "crossover") of services, CWF will generate an A/B Crossover error code. These are returned on the reply Trailer 13 and will contain only one A/B crossover error code.

Process Description

1. The first step in this non-Institutional Part B claims processing process is that OIS/BAMG arranges for the X12 837 standards Health Insurance Portability and Accountability Act of 1996 (HIPAA) Guide, hereafter referred to as Technical Reports 3 (TR3), and the Medicare Companion Guide to be available to the MAC via download.

   Impact: ***No Impact.***

2. The MAC sends the editor updates and the partner updates to the Electronic Data Interchange (EDI) Front end for validation and syntax compliance.

   Impact: ***No Impact***.

3. The MAC receives confirmation of an active rule set after test setups have been run from OIS/BAMG.

   Impact: ***No Impact.***

4. The MAC reaches an agreement with the Provider for use of the non-Institutional Claims Processing Process.

Impact: ***No Impact.***

5. There are three ways in which a claim is entered into MCS for non-Institutional Part B Claims Processing. This process contains ICD codes.

   a. Through the front end EDI in the X12 837 packet
   b. Scanned In, and
   c. Through Direct Data Entry (1500 format) – for claims examiners.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

   Risk: There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in a claim denial, overpayment or underpayment to occur during processing.

6. The provider sends the 1490S named PATIENT'S REQUEST FOR MEDICAL PAYMENT (English/Spanish), a professional paper form (CMS 1500) which the MAC receives and controls. It is scanned into the MCS application system by the MAC. Regardless of whether the claim is scanned in or entered by direct data entry it is treated as an electronic claim once it is sent to MCS. This process contains ICD codes.

   Impact: There is ***no impact*** to the scanning process, yet the paper forms contain ICD codes.

   Risk: There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in claim denial, overpayment, or underpayment to occur during processing.

7. The MAC creates a Part B Application Record. These claims do not come through the front end EDI but are received in MCS in the 1500 non-Institutional claim flat file for Part B claims processing. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

8. When a Medicare Part B Claim is sent through the front end EDI, it is split and mapped via X12 837 packet to the application file. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

9. The non-institutional Part B claim is converted into the 1500 non-Institutional Claims Format via the front end EDI and is sent to MCS for Part B non-institutional claims processing. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

10. Once MCS receives the Part B Application Record, it is verified for compliance to TR3 Rules. HIPAA edits may also occur in the EDI front end. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length requirements needed to the standard system.

11. The Part B non-institutional claim is then verified for claims consistency with NCDs and LCDs. A Code Set File, which has hard coded edits, is verifying these codes for claims consistency. The claim leaves this step in the process with indicators for action, e.g. denial, acceptance, discounts etc. The NCD and LCD claims consistency process contains ICD codes, as well as CPT and HCPCS codes.

    Impact: The process impact is ***high*** or less as stated due to the following:

    - There is a ***high*** impact to the MCS claims process since the claims process includes ICD diagnosis codes based upon the DOS on the claim. The ongoing use of ICD-9 will be required by the standard systems for an extended period of time. Not only must the systems accommodate the receipt of claims for more than a year after a service was rendered, the systems must accommodate processing of claim adjustments for those dates of service for several years beyond implementation of ICD-10.

    - There is a ***high*** impact to MCS longitudinal data since ICD data is included in claims and there are linkages by beneficiary data across years and files. Although a crosswalk between ICD-9 and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Also, as the implementation of ICD-10 is expected to be accomplished on a fiscal year basis, nine months of data will be in the ICD-9 classification format and 3 months of that year will be in the ICD-10 classification.

    - CMS implements formal coverage policies on a national scale through NCDs that describe the conditions under which Medicare coverage for specific items and services is granted, limited, or excluded. The Office of Clinical Standards and Quality (OCSQ) oversee and are responsible for national quality initiatives that include ICD codes. The OCSQ Coverage and Analysis Group (CAG) work in collaboration with CMM policy development components to create the national coverage determinations. NCDs are binding on all MACs and they may not have local policies that conflict with a NCD. The MACs may develop

local policies in areas where an NCD is silent. There is a need to duplicate NCD file edit changes within MCS to include ICD-10 codes based on date of service.
There is a ***minor***[8] impact to the claims process for addition of the new ICD-10 NCDs to MCS. The process is controlled during implementation of the NCDs in the MCS standard systems under comprehensive control and testing during the CMS Change Management Control/Change Request (CR) process.

Risk:

- The Medicare Fee-For-Service contractors will have to create new ICD-10 LCDs to reflect the coverage language in the existing ICD-9 LCDs. There is a ***high*** risk of misinterpretations and coding errors will occur if existing LCDs are created exclusively by the MACs utilizing manual coding crosswalks. If the same newly created LCDs with errors are translated into the MAC contractor's MCS edits it would result in the denial, underpayment, or overpayment of claims.

- CMS components will create new ICD-10 NCDs to reflect the coverage language from the existing ICD-9 NCDs. There is a ***minor*** risk to the claims process that coding errors in NCDs would occur due to collaboration between CAG and CMM Division of Acute Care (DAC) coding expertise during NCD development. Also, risk is lessened by the implementation of the NCDs in the MCS standard systems under the comprehensive control and testing during the CMS Change Management Control/Change Request (CR) process.

12. In the next activity, the verified Part B claim is sent to the MCS/Super/OPS where an audit on the related ICD diagnosis codes occurs and suspends the claims from the claims process that are deemed medically unlikely to occur. These claims are sent to the Medicare Integrity Operations via the Pre-Payment Medical Review Process.

    The *Pre-Payment Medical Review Process Summary Report* contains the detail and illustration of the interdependent process.

    Impact: ***No Impact.***

13. The verified Part B Claims that surpass the MCS audit are sent through for Pricing; a fee schedule is used by MCS during this activity. The pricing source, Ambulance Fee Schedule, Clinical Laboratory Fee Schedule, and the Physicians Fee Schedule are utilized. The pricing source depends on the type of bill (TOB).

    Impact: ***No Impact.***

[8] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.

14. The Part B Priced Claim is then sent to CWF for eligibility determination and payment authorization. The whole claim is not sent to CWF. CWF host communicated with the relevant contractors. Trailers are used to communicate with the contractor as to why the contractor is receiving this record. CWF sends the Adjudicated Claim within 3 to 5 days. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

15. CWF receives the priced claim from MCS and performs a consistency edit to ensure it is in the correct format. Because CWF is not HIPAA compliant, it only accepts one format. CWF determines eligibility and utilization. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

    - The CWF edits are run simultaneously against the ICD-9 codes in CWF. By January 2009, the CWF business owner will have a generalized equivalent mapping for ICD-10 in order to mitigate impact.

16. CWF sends the adjudicated claim to the Archiving Process – Common Working File Medicare Quality Assurance (CWFMQA).

    Please refer to the *Manage CMS System Repositories and their Data Outputs Archiving Process Summary Report* and illustration for more detailed information on this process. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

17. CWF produces an advisory file with Medicare amount payable in association with each occurrence of a Beneficiary Other Insurance (BOI) record The advisory file contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

18. The Medicare Payable Advisory File, with CWF trailers, including 29 trailer, are sent from CWF to MCS. MCS will use this information to select the claims where there is a secondary payer to crossover to the Coordination of Benefits Contractor (COBC). This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

19. The beneficiary history and profile information is sent to the EDB. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

20. MCS sends a Coordination of Benefits (COB) flat file containing claims for beneficiaries with other insurance for inclusion in the Coordination of Beneficiary Agreement Crossover Process. This process contains ICD codes.

    Please refer to the Coordination of Beneficiary Agreement Crossover Process for more detailed information on this process.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

21. CWF sends payment approval directly to MCS. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

22. MCS accepts the payment approval and forwards to the accounting process for Part B Payment.

    Impact: ***No Impact.***

23. In the next activity, MCS receives the Part B claims payment.

    Impact: ***No Impact.***

24. MCS splits the EFT (electronic fund transfer) payments from the paper payments.

    Impact: ***No Impact.***

25. Payments for EDI recipients are sent via an Electronic Fund Transaction (EFT) Payment Flat File in an EFT record to the EDI back end process.

    Impact: ***No Impact.***

26. The payments for non-EDI transactions are then captured in a Paper Check File. This file is sent to the MAC for payments and paper checks are then distributed to the provider.

    Impact: ***No Impact.***

27. After Eligibility Determination and payment authorization is determined, CWF sends the claims payment outcome advice to MCS.

    Impact: ***No Impact***.

28. MCS receives the claim payment outcome advice and formal claim acceptance or denial advice is sent, by paper Standard Paper Remit (SPR), back to the Provider.

    Impact: ***Minor.***

    - Programmers may require training to understand the changes to the tables and reports for ICD-10 codes.

29. A Medicare Summary Notice (MSN) is sent to the beneficiary. This process contains ICD Codes.

    Impact: ***Minor.***

    - Programmers may require training to understand the ICD-10 code changes to the tables\reports.

Process Risk Assessment

The current process for updating the MCS ICD Diagnosis code set is a manual communication via the CR process to the MAC contractors. The ***high***[9] risk associated with the manual updating of the ICD-10 Diagnosis code set files during implementation could be eliminated with CMS requiring the automation of the ICD-10 load process to allow for greater ease and flexibility of installing upgrades to the code set.

There is a ***high*** risk to the MCS claims process for claim denial or error due to need to simultaneously process both ICD-9 and ICD-10 code sets after implementation of ICD-10. Currently MCS processes claims based upon date of service on a claim; the ongoing use of ICD-9 will be required by the standard systems for an extended period of time. Not only must the systems accommodate the receipt of claims for more than a year after a service was rendered, the systems must accommodate processing of adjustments for those dates of service for several years. Therefore, dual processing of ICD-9 and ICD-10 must be planned and accommodated to continue to a date determined appropriate by CMS.

[9] A High or Red Level Process will stop, work or payment will cease at time of transition

The Medicare Fee-For-Service contractors will have to create new ICD-10 LCDs to reflect the Medicare coverage language in the existing ICD-9 LCDs. There is a ***high*** risk of misinterpretations and coding errors will occur if existing LCDs are created exclusively by the MACs utilizing manual coding crosswalks. If the same newly created LCDs with errors are translated into the MAC contractor's MCS edits it would result in the denial, underpayment, or overpayment of claims.

There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) which would result in a claim denial, overpayment or underpayment to occur during processing.

Claims Processing – Part B (Durable Medical Equipment) VMS and CWF Impact Rank: High

Table 8. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Office of Information Services(OIS): High[10] or Red Level	Office Information Services(OIS)/ Business Applications Management Group (BAMG) ranking: High or Red Level

Process Overview

The ViPS Medicare Shared System (VMS) is a mainstream standard system managed by the CMS Office of Information Systems (OIS) Business Application Management Group (BAMG). ViPS, a CMS contractor, is the standard system maintainer. VMS is used to process claims for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) and other services/supplies not included for payment in other Medicare Part A or B provider services. VMS includes much of the Part B functionality for claims collection, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing and reporting. VMS also includes Certificate of Medical Necessity (CMN) requirements and supplier interfaces.

The Common Working File (CWF) contains information about all Medicare beneficiaries. The VMS shared system interfaces directly with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

CMS issues instructions for implementing an annual fee schedule and/or updating payment amounts quarterly for DMEPOS. CMS issues a quarterly release of program specification changes which are created by various CMS division components utilizing the Change Management Process. Any VMS standard systems software specification changes are communicated by CMS components utilizing the Change Request/Change Management Process via Electronic Change Information Management Portal (eCHIMP) system. The standard systems change process is coordinated by Medicare Contractor Management Group (MCMG) Division of Changes and Operations Management (DCOM). The accuracy of the instructional

specification changes which contain International Classification of Disease (ICD) diagnosis codes are of ***high*** impact and critical to provider billing for beneficiary services and the OIS standard system updates which are utilized by the fee-for-service(FFS) contractors for claims processing.

[10] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.

For a given fiscal year, the quarterly release schedule includes standard systems and claims processing specifications including ICD codes is as follows:

- Initial Release — October 1,
- First Quarterly Release — On or about October 15,
- Second Quarterly Release — On or about January 15,
- Third Quarterly Release — On or about April 15,
- Fourth Quarterly Release — On or about July 15.

Effective July 1, 2009, CMS requires the VMS standard system to capture and process all ICD diagnosis codes reported on a claim up to the maximum allowed by the ASC X12N 837P Transaction, Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 4010A 1 claim format. This will also require passing this information to the CWF for processing and the National Claims History (NCH) for storage as written in Change Request (CR) 6068.

The following subsystems have been identified by ViPS, the Standard System Maintainer (SSM), as requiring changes as a result of the implementation of ICD-10 Diagnosis codes:

- 837 inbound and outbound processing,
- National Council for Prescription Drug Program (NCPDP) inbound and outbound processing,
- Online Claims Processing (VMON) and Online Quality Control (OQC),
- Beneficiary Update and Display System (BUDS),
- Claims History Inquiry by Provider (CHIP) System,
- Automated Claims Examination System (ACES),
- Master Procedure /Diagnosis Record System (APPL/4),
- Certificate of Medical Necessity (CMN) Processing System (VDME),
- Automated Paperless Exception System (APEX),
- ViPS Notepad System (VNOT),
- Automated Development System (ADS),
- VMS Automated Letter Generation System (VLGS),
- Claim Adjudication and Adjudication Reports, and,
- Medical review/utilization review (MRUR).

The following have been identified by the ViPS SSM as a downstream users of VMS (not all inclusive):

- HETS Beneficiary Eligibility Suite of Systems Transactions (BESST),
- HETS Medicare Eligibility Integration Contractor (MEIC),
- Risk Adjustment System (RAS),
- PM,
- Data Extract System (DESY),

- Medicaid Statistical Information System (MSIS)/ National Medicare Utilization Database (NMUD),
- National Claims History (NCH),
- Front-End Risk Adjustment System (FERAS),
- Common Working File Medicare Quality Assurance System (CWFMQA),
- Integrated Data Repository (IDR),
- Common Electronic Data Interchange (CEDI),
- Durable Medical Equipment Medicare Administrative Contractors (DME MACs),
- Next Generation Desktop (NGD),
- Center for Analytical Review & Education (CARE),
- Comprehensive Error Rate Testing (CERT),
- Medicare Beneficiary Database (MBD).

Related Processes

Table 9. VMS Claims Processing Illustration below reflects the pertinent use by the DMEPOS fee-for-service (FFS) payment policy, associated claims processing applications, and any associated dependent patient assessment databases external to the claims process used for the FFS payment policy development. Relevant areas associated with or without ICD codes are noted in the illustration.

Table 9. VMS Claims Processing Illustration

FFS Payment Policy	**Medicare Part A**	**Medicare Part B**	**MCE**	**I/OCE** (Diagnosis code field 1-5 edit)	**Fee Schedule**	**Pricer Software**	**MS-DRG Grouper** (ICD Codes)	**Case-mix Grouper** (ICD codes)	**Patient Assessment Instrument**
DMEPOS		√			√				

VMS interfaces/interacts with other CMS applications such as, fee schedules. CMS requires and schedules standard system quarterly updates. Each Medicare contractor must load the quarterly updates into their claim processing system. These quarterly updates take place each January, April, July, and October.

Process Description

1. The first step in this non-Institutional Part B claims processing process is that OIS/BAMG arranges for the X12 837 standards Health Insurance Portability and Accountability Act of 1996 (HIPAA) Guide, hereafter referred to as Technical Reports 3 (TR3), and the Medicare Companion Guide to be available to the MAC via download.

   Impact: ***No Impact.***

2. The DME MAC sends the editor updates and the partner updates to the electronic data interchange (EDI) front end for compliance.

   Impact: ***No Impact.***

3. The DME MAC receives confirmation of an active rule set after test setups have been run from OIS/BAMG.

   Impact: ***No Impact.***

4. The DME MAC reaches an agreement with the Supplier for use of the Durable Medical Equipment Part B Claims Processing Process.

   Impact: ***No Impact.***

5. There are different ways in which a beneficiary or supplier claim is entered for DME Part B Claims Processing:

   a. Through the front end EDI in the X12 837 packet (VMS DME Format),
   b. Through Direct Data Entry (DDE),
      1. Scanned In, or,
      2. Entered by DME MAC manually.

   These processes contain ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

Risk: Beneficiaries are not required to submit ICD-9 codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. For beneficiary-submitted claims, the DME MAC must develop the claim to determine a current and valid ICD code and may enter the code on the claim. There is a ***high*** risk of ICD coded data being keyed incorrectly during direct data entry (DDE) at the DME MAC which would result in a claim denial, overpayment or underpayment to occur during processing.

6. The Beneficiary sends an Institutional paper form, called the PATIENT'S REQUEST FOR MEDICAL PAYMENT (English/Spanish) (CMS 1490S) or the Supplier sends a professional paper form (CMS 1500) which the DME MAC receives and controls. The way in which the claim is entered depends on the options for manual claims entry. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system

   The DME MAC either scans the claim into the VMS application system or manually direct enters the Part B claim in order to send to the VMS system for claims processing. The DME MAC translates the beneficiary diagnostic information into ICD diagnosis description of the service performed to ICD Codes for VMS claims processing. This process contains ICD codes. The claims are sent to VMS to go through Pre-Pass edits.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system

   Risk: There is a ***high*** risk of coded data being keyed incorrectly during direct data entry (DDE) by the DME MAC which would result in a claim denial, overpayment or underpayment to occur during processing.

7. Once the DME Part B claim is entered into VMS the claim goes through Pre-Pass edits which verifies compliance to the TR3. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system

8. The verified DME Part B Claim is entered into the VMS DME data store and converted into the VMS DME Part B Flat File. All DME Part B claims that do not get entered through the front end EDI are translated in this fashion. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system

9. The non-EDI claims meet the claims that do go through the front end EDI in the next activity box; where claims are validated for compliance with Medicare Rules for DME Part B Claims. This process contains ICD codes.

   Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

10. When a DME Part B Claim is sent through the front end EDI, it is mapped via X12 837 packet to the Application Files.

    Impact: ***No impact.***

11. It is converted into the VMS DME Claims Flat File Format in the front end EDI and is sent to VMS for VMS DME claims processing. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

12. Once VMS receives the VMS DME claim, it is validated for compliance to validate Medicare Rules for DME Part B Claims. All claims, electronic, OCR and paper, are subject to VMS edits. This includes beneficiary eligibility, supplier edits and all Medicare rules. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

13. Received claims are sent to the Claims in Progress data store. This process contains ICD codes. There is one data store for electronic claims in VMS. Claims in progress reside in the Claims in Progress (CIP) file until they are adjudicated. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

14. The DME Part B claim is then verified for claims consistency with National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). The Medical Unlikely Edits (MUEs), which include hard coded edits, is verifying these codes for claims consistency simultaneously. The MUEs contain Current Procedural Terminology (CPT)® codes and Healthcare Common Procedure Coding System (HCPCS) codes which ICD has ***no*** impact. The NCD and LCD claims consistency process contains ICD codes, as well as CPT and HCPCS codes.

    Impacts: The process impact is ***high*** or less as stated due to the following:

    - There is a ***high*** impact to the VMS claims process since the claims process includes ICD diagnosis codes based upon the DOS on the claim. The

ongoing use of ICD-9 will be required by the standard systems for an extended period of time. Not only must the systems accommodate the receipt of claims for more than a year after a service was rendered, the systems must accommodate processing of claim adjustments for those dates of service for several years beyond implementation of ICD-10.

- There is a ***high*** impact to VMS longitudinal data since ICD data is included in claims and there are linkages by beneficiary data across years and files. Although a crosswalk between ICD-9 and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Also, as the implementation of ICD-10 is expected to be accomplished on a fiscal year basis, nine months of data will be in the ICD-9 classification format and 3 months of that year will be in the ICD-10 classification.

- CMS implements formal coverage policies on a national scale through NCDs that describe the conditions under which Medicare coverage for specific items and services is granted, limited, or excluded. The Office of Clinical Standards and Quality (OCSQ) oversee and are responsible for national quality initiatives that include ICD codes. The OCSQ Coverage and Analysis Group (CAG) work in collaboration with Centers for Medicare Management (CMM) policy development components to create the national coverage determinations (NCDs). Medicare Contractors cannot have local policies that conflict with an NCD. The DME MACs may, however, develop local policies in areas where an NCD is silent, left to contractor discretion, or where they want to supplement an existing NCD There is a need to duplicate NCD file edit changes within VMS to include ICD-10 codes based on the DOS.

  There is a ***minor***[11] impact to the claims process for addition of the new ICD-10 NCDs to VMS. The process is controlled during implementation of the NCDs in the VMS standard systems under comprehensive control and testing during the CMS Change Management Control/Change Request (CR) process.

Risks:

- The DME Medicare FFS Contractors, DME MACs, will have to create new ICD-10 LCDs to reflect the coverage language in the existing DME MAC ICD-9 LCDs. There is a ***high***[12] risk that misinterpretations and coding errors will occur if new LCDs are created exclusively by the DME MACs

[11] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.
[12] A High or Red Level Process will stop, work or payment will cease at time of transition

utilizing manual coding crosswalks. If the same newly created LCDs with errors are translated into the DME MAC contractor's VMS edits it would result in the denial, underpayment, or overpayment of claims.

- CMS components will create new ICD-10 claims processing instructions from the existing ICD-9 NCD claims processing instructions. There is a ***minor***[13] risk to the claims process that coding errors in NCDs claims processing instructions could occur during the drafting of the NCD claims processing instructions by CAG and CMM Division of Acute Care (DAC) coding expertise. Also, risk is lessened by the implementation of the NCDs in the VMS standard systems under the comprehensive control and testing during the CMS Change Management Control/CR process.

15. The verified DME Part B Claims are sent through for pricing. The CMS fee schedule and is used by VMS during this activity.

    Impact: ***No impact.***

16. The Part B Priced Claim is then sent to CWF for eligibility determination and payment authorization.

    Only when a claim has passed all online and batch edits will the claim be sent to CWF for payment authorization. The diagnosis codes associated with that claim are sent to CWF on the query record, in the CWF format. The only impact to processing is to accommodate the CWF format when sending the diagnosis codes. It has been discussed that there will be a indicator attached to each diagnosis code to indicate whether it is ICD-9 or ICD-10. CWF will also have this indicator on the query record. VMS will systematically build the CWF query record from the claim, populating the diagnosis fields appropriately.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

17. CWF receives the priced claim from VMS and performs a consistency edit to ensure it is in the correct format. Because CWF is not HIPAA compliant, it only accepts one format. CWF determines eligibility and utilization. CWF receives a query in the CWF format; this does not include all fields that are included on the VMS Claim record. CWF performs eligibility, utilization, consistency and Par A/B crossover conflicts. CWF will send a reply with either the error or an approval to pay. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

[13] A Minor or Green Level Process will continue with minimal or routine modifications to the process

- The CWF edits are run simultaneously against the ICD-9 codes in CWF. By January 2009, the CWF business owner will have an equivalent mapping for ICD-10 in order to mitigate impact.

18. CWF sends the adjudicated claim to the Archiving Process – Common Working File Medicare Quality Assurance (CWFMQA).

    Please refer to the Manage CMS System Repositories and their Data Outputs Archiving Process Summary Report and illustration for more detailed information on this process. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

19. CWF produces an advisory file with Medicare amount payable in association with each occurrence of a Beneficiary Other Insurance (BOI) record The advisory file contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

20. This beneficiary history and profile information is sent to the CMS Enrollment Database (EDB). This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

21. VMS sends a Coordination of Benefits (COB) flat file for inclusion in the Coordination of Beneficiary Agreement Crossover Process. This process contains ICD codes.

22. Please refer to the Coordination of Beneficiary Agreement Crossover Process Summary Report for more detailed information on this process.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

23. CWF sends payment approval directly to VMS. This process contains ICD codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

24. VMS accepts the payment approval and forwards to the accounting process for DME Part B Payment.

    Impact: ***No Impact.***

25. In the next activity, VMS receives the Part B claims payment.

    Impact: ***No Impact.***

26. VMS splits the electronic fund transfer (EFT) payments from the paper payments.

    Impact: ***No Impact.***

27. Payments for EDI recipients are sent via an Electronic Fund Transaction Payment Flat File in an EFT record to the EDI back end process.

    Impact: ***No Impact.***

28. The EDI back end receives the DME Part B claims where the claim payment is mapped to the X12 820 EFT for batch payment to the Supplier.

29. The payments for non-EDI transactions are then captured in a Paper Check File. This file is sent to the DME MAC for payments and paper checks are then distributed to the Supplier.

    Impact: ***No Impact.***

30. After Eligibility Determination and payment authorization is determined, CWF sends the claims payment outcome advice to VMS.

    Impact: ***No Impact.***

31. VMS receives the claim payment outcome advice and formal claim acceptance or denial advice is sent, by paper SPR, back to the Supplier.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

    - Programmers may require training to understand changes to the tables\reports for ICD-10 codes. This impact is ***minor*****.**

32. An explanation of benefits is sent through a Medicare Summary Notice to the beneficiary. This process contains ICD Codes.

    Impact: The process impact is ***high*** due to ICD-10 character and field length change requirements needed to the standard system.

    Programmers may require training to understand changes to the tables\reports for ICD-10 codes. This impact is ***minor*****.**

Process Risk Assessment

For supplier electronically submitted DMEPOS claims, a valid ICD diagnosis code, which most fully explains the patient's diagnosis, is required. CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the DMEPOS claim. Without comprehensive ICD-10 training at the suppliers there is a ***high*** risk of error for ICD-10 codes that may result in denial, underpayment, or overpayment of claims.

There is a ***high*** risk to the VMS claims process for claim denial or error due to the need to simultaneously process both ICD-9 and ICD-10 code sets after implementation of ICD-10. Currently VMS processes claims based upon date of service on a claim; the ongoing use of ICD-9 will be required by the standard systems for an extended period of time. Not only must the systems accommodate the receipt of claims for more than a year after a service was rendered, the systems must accommodate processing of adjustments for those dates of service for several years. Therefore, dual processing of ICD-9 and ICD-10 must be planned and accommodated to continue to a date determined appropriate by CMS.

The current process for updating the VMS ICD diagnosis code set is a manual communication via the CR process to the DME MAC contractors. The ***high*** risk associated with the manual updating of the ICD-10 Diagnosis code set files during implementation could be eliminated with CMS requiring the automation of the ICD-10 load process to allow for greater ease and flexibility of installing upgrades to the code set.

It is important to note that VMS only requires the utilization of the ICD diagnosis file, and will not be impacted by the transition of ICD-10 Procedural Coding System (PCS) for procedures which is used on Part A inpatient claims.

Manage CMS System Repositories and their Data Outputs Process
Impact Rank: High

Table 10. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Centers for Managing CMS System Repositories and their Data Outputs Process: High[14] or Red Level	Office of Information Systems (OIS)/Enterprise Data Group (EDG): High or Red Level

Process Overview

Managing CMS System Repositories and their Data Outputs Process includes management, provision and storage of all CMS claims data submitted by Fiscal Intermediaries, Carriers, States and Medicare Administrative Contractors (MAC) related to all Medicare and Medicaid beneficiary care. All claims data submitted to CMS is stored and utilized for payment, payment policy, demonstrations, Program Integrity, clinical and related research projects (internal and external) as well as analysis for current and future reimbursement methods. All submitted information is stored in repositories and databases accessed for multiple purposes and are utilized by virtually all areas of CMS as well as external contractors, researchers, providers and the general public.

The systems integral to providing information to other databases and repositories are the Common Working File (CWF), National Claims History (NCH) file, National Medicare Utilization Database (NMUD), Medicaid Statistical Information System (MSIS) and the Integrated Data Repository (IDR). These databases and systems supply Medicare and Medicaid data to a host of other systems across the agency. Data files are created and utilized from these archive systems and additional data sources to support CMS activities.

The impacts to CMS are on all systems, files and data repositories storing ICD coded data. These systems and files provide the information related to clinical patient care, costs, reimbursement methodologies and program integrity to multiple users/researchers for CMS activities as well as external researchers and auditors. ICD data is contained and stored in CMS systems and is utilized for trending of clinical outcomes, cost, reimbursement methodologies, research, designing demonstrations and a host of other CMS activities. ICD-10 coding format is an expanded classification for specificity and granularity. Field size in all databases and systems will require expansion to accommodate ICD-10 data. Mapping of ICD-9-CM codes to ICD-10-CM and ICD-10-PCS coded data will be required to accommodate trending of diagnosis/procedure information and research impacting numerous CMS activities. Although a crosswalk between ICD-9-CM and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Consistency edits are performed on submitted claims throughout the claims processing in the Common Working File Medicare Quality Assurance (CWFMQA) and other systems for appropriateness of care and medical necessity (e.g., Hysterectomy only performed on female patient). These edits will require modification to accommodate ICD-10 codes.

[14] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.

Office of Information Systems (OIS)/Enterprise Data Group (EDG) is the maintainer/owner for the majority of the databases and related systems/files for storage of beneficiary data.

Related Processes

Preceding Processes

- Detail regarding the processes for CWF and the claims processing systems are described in the Claims Processing – Part A – FISS and CWF, Claims Processing – Part B – MCS and CWF and Claims Processing – VMS/DME and CWF. These processes describe how claims data is collected, edited and then, sent to CWFMQA and CMS Repositories.

Subsequent Processes

- **Medicare Integrity Operations**– Perform Data Analysis Process utilizes the data from Part B Extract and Summary System (BESS) and the Healthcare Information System (HCIS) Data File.

- **Medicare Integrity Operations**– Medicare Integrity Operations Processes utilize claims data from NCH.

- **Conduct Evaluations Process and Research Projects Process**- NCH data from TAP Files and from NMUD may be utilized in ongoing research and evaluation projects.

- **Conduct Demonstrations Process -** NCH, NMUD and SAF data may be utilized in ongoing demonstrations for planning and implementation.

- **Conduct Research Process, Collect and Publish Medicare Statistics Process and Deliver Chronic Condition Data** - MedPAR File and SAF data are utilized to build the Annual Person Summary (APS) and Catastrophic File System (CFS), which are used to build the tables in the Medicare Statistical Supplement. In addition, NCH is utilized to populate the Chronic Condition Data Warehouse (CCW).

- **Develop and Implement Payment Policy Process -** This process utilizes data from the MEDPAR File. CMS refines Medicare payment policy through annual rulemaking and responds to changes in clinical practice and industry operations.

- **Appeals Process -** NCH and NMUD data is utilized by Medicare Appeals System (MAS) for tracking appeal cases for Medicare Part A and B.

- **Call Center Claim Inquiry Process -** NCH and NMUD data is utilized to support call center operations by making the claims data available via the Next Generation Desktop (NGD) utilized by call center employees.

- **Develop and Support Quality Measures and Payment Initiatives Process** utilizes data from NCH.

- **Risk Adjustment Process**. NMUD data is utilized in the Risk Adjustment System (RAS).

Process Description

Claims data is sent to the Common Working File (CWF) on a daily basis from the Medicare claims processing systems. Detail regarding the processes for CWF and the claims processing systems are described in the Claims Processing – Part A – FISS and CWF, Claims Processing – Part B – MCS and CWF and Claims Processing – VMS/DME and CWF. CWF sends daily feeds of claims data to the CWFMQA system for validation and preparation for archiving in CMS archive systems, including National Claims History (NCH) File, National Medicare Utilization Database (NMUD) and the Integrated Data Repository (IDR). These archive systems supply Medicare data to a host of other systems across the agency for policy determination, research, reporting and other vital CMS functions. In addition, data files are created using the data from these archive systems and additional data sources to support CMS activities. For example, the Medicare Provider Analysis & Review (MedPAR) File is built using data from NCH, Health Insurance Skeleton Eligibility Write-off (HISKEW) file, and from the Social Security Administration. Data from the MedPAR File is utilized to develop payment policy and is published in CMS' annual Statistical Supplement.

This report provides information on the CMS System Repositories and the data files built from those repositories to provide an understanding of the data flow, the system usage and the ICD-10 transition impact.

CWF Medicare Quality Assurance (CWFMQA)

Description

CWF Medicare Quality Assurance (CWFMQA) validates CWF claims data for consistency, utilization, enrollment/duplicate checking, and frequency distribution. CWFMQA performs edits on the data, identifies possible anomalies to OIS/BAMG, and annotates the claims with an edit code to denote data deficiencies. Office of Information Systems (OIS)/Enterprise Data Group (EDG) is the Business Owner of CWFMQA and OIS/EDG/Division of Integrated Data Program Management (DIDPM) is the System Owner.

System Inputs

CWFMQA receives daily feeds of Medicare Part A and B claims and enrollment data from the CWF. In addition, CWFMQA receives a daily extract file from CWF with claims information from teaching hospitals, Indirect Medical Education (IME) and Graduate Medical Education (GME) files, so it can be loaded into NCH and used for MEDPAR processing. This claim information has ICD coded data. In the future, CWFMQA will be receiving Part C data from CWF. The Part C information is required for reporting and calculations for Disproportionate Share Hospital (DSH) payments.

System Process

1. CWFMQA receives daily feeds from CWF of Part A and B claims data and verifies the completeness of the files sent from CWF.

2. CWFMQA extracts and sends enrollment maintenance records (Date of Death Notices, Hospice Notice of Election, MSP Data and Transaction Updates) to the Enrollment Database. CWFMQA also extracts and sends ESRD Method of Payment Elections to OCSQ, and prepares Part A and Part B claims files for the IDR.

3. CWFMQA creates the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) File from the Durable Medical Equipment claims received from CWF. The SADMERC file is utilized by the Competitive Bidding Implementation Contractor (CBIC) and SADMERC Contractor. The work performed by SADMERC Contractor is transitioning to the Pricing, Data Analysis and Coding (PDAC) Contractor. The SADMERC file contains ICD codes.

4. CWFMQA formats the data to be loaded into CMS legacy systems, e.g., National Claims History (NCH) File and National Medicare Utilization Database (NMUD).

5. CWFMQA performs a set of consistency edits to ensure data quality (similar to those edits in CWF). This editing examines the ICD codes. For example, the edits verify a procedure to ensure an adult procedure is not preformed on a child.

6. CWFMQA claims data is stored in a file system, not a database or repository prior to loading them into NCH.

System Outputs

- CWFMQA sends a weekly Part A and Part B files to NCH. CWFMQA gets data in for every service year, the NCH stores data for the current year and prior 3 years. This data contains ICD codes.

- CWFMQA builds National Claims History Summary (NCHSUM) and Monthly Bill and Payment Records Processing System (MBPRP) files. CWFMQA then builds National

Claims History Statistical Tabulation System (NCHSTS) from MBPRP files. This data contains ICD codes.

- CWFMQA builds daily and weekly files in NCH format for IDR storage of Part A and B Claims. This data is all claims data received by CWFMQA for all dates. This data contains ICD codes.

System Impacts

- CWFMQA receives and processes claims containing ICD-9 coded data. CWFMQA performs edits on the claims data and will have to be able to process both ICD 9 and ICD 10 codes after the transition to ICD-10. The functions within CWFMQA will have to account for the expanded format of ICD-10 codes and the additional specificity of ICD-10. The edits in CWFMQA may be able to provide additional functionality in checking the accuracy and validity of claims, by using the detailed information provided by the new ICD-10 codes. Output files, IME/GME files and SADMERC file, created by CWFMQA to support other activities will need to accommodate both ICD-9 and ICD-10, following the transition. This impact is ***medium***[15]**.**

- The staff supporting CWFMQA will require training to understand the differences between ICD-9 and ICD-10 to develop the changes required in CWFMQA. This impact is ***minor***[16].

Primary CMS Archive Repositories

- National Claims History (NCH)
- National Medicare Utilization Database (NMUD)
- Integrated Data Repository (IDR)
- Medicaid Statistical Information Statistics (MSIS)

National Claims History

Description

National Claims History (NCH) is the CMS system of record for Medicare Part A and B claims data. NCH is loaded monthly with data from CWFMQA and contains claims data from 1991 to

[15] A Medium or Orange Level Process will have an impact that, if the impact occurs, will cause noticeable cost (and/or schedule) increases to the project.

[16] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.

present. NCH contains ICD-9 coded data. NCH is the primary source of claims information for other systems at CMS and for groups requesting claims data. NCH is a flat file repository and is one of CMS's legacy applications. NCH is also known as Nearline. OIS/EDG/DIDPM is the Business/System Owner of NCH.

System Inputs

- CWFMQA sends the NCH weekly files (4 or 5 weekly files depending on the number of Fridays in that month) of all claims transactions received. This data contains ICD codes.

System Process

- NCH stores Medicare Part A and B claims data with ICD codes in flat file format.

System Outputs

- NCH provides data to NMUD on a monthly basis. NMUD contains the same data as NCH.
- NCH builds NCH TAP Files on a monthly basis. NCH TAP files are extracts from NCH to provide easier access to claims data for research and policy initiatives, limiting the requests going directly against the NCH File.
- NCH provides data to build the MedPAR File via the NCH TAP Files.
- NCH provides data to build the Standard Analytical Files (SAF) via NCH TAP Files.
- NCH provides data to build Medicare Actuarial Data System (MADS).
- NCH data is accessible via the Data Extract System (DESY) to accommodate data requests.
- NCH provides data to the following processes:
- Conduct Evaluations and Research Projects Process. NCH data may be utilized in ongoing research and evaluation projects.
- Call Center Process. NCH data is utilized to support call center operations.
- Appeals Process. NCH data is utilized by Medicare Appeals System (MAS) for tracking appeal cases.
- Medicare Integrity Operations– Perform Data Analysis Process, Post-Payment Review and Pre-Payment Review Processes utilizes data from NCH
- Conduct Demonstrations Process. NCH data may be utilized in ongoing demonstrations for planning and implementation.
- Conduct Research Process, Deliver Chronic Condition Data. NCH is utilized to populate the Chronic Condition Data Warehouse (CCW).
- Call Center Claim Inquiry Process. NCH data is utilized to support call center operations by making the claims data available via the Next Generation Desktop (NGD) utilized by call center employees.
- Develop and Support Quality Measures and Payment Initiatives Process utilizes data from NCH.

System Impacts

- NCH contains claims data from 1991 to present and stores ICD-9 coded data. NCH will require modification to store both ICD-9 and ICD-10 codes. There will not be a crosswalk of the data to convert older claims with ICD-9 coded data to ICD-10 format. Claims will be stored with their original diagnosis and new claims (post-transition) will be stored with ICD-10 codes. NCH will be required to store both formats. This impact is ***high*.** NCH is written in an older programming language (COBOL) and CMS has limited staffing resources with knowledge related to updating NCH. In addition, there is limited system documentation. Updates will require significant lead time to develop a full understanding related to implementing the requested changes and the impact of system changes.

- The staff supporting NCH may require training to understand ICD-10 codes and the differences between the ICD-9 and ICD-10 to properly plan and implement the necessary changes to NCH. This impact is ***minor*.** The ICD-10 changes will be focused on the expanding the field size for storage and for creating the necessary system outputs.

National Medicare Utilization Database

Description

National Medicare Utilization Database (NMUD) is a relational database containing Medicare Part A and B from 1998 to present. NMUD is loaded monthly with data from the NCH, following NCH's receipt and loading of data from CWFMQA. NMUD contains the same data as NCH, but is stored in a relational database for easier access to data. NMUD does contain ICD-9 coded data. NMUD is owned and maintained by OIS/EDG/DIDPM.

System Inputs

- NMUD is loaded monthly with Medicare Part A and B claims data from NCH.

System Process

- NMUD stores Medicare Part A and B claims data in a relational database.

System Outputs

- NMUD data is utilized to build Standard Analytical Files (SAF).
- NMUD data is accessible via the Data Extract System (DESY) to accommodate data requests.

- Healthcare Information System (HCIS) accesses NMUD data for Program Integrity activities.
- NMUD provides data to the following processes:
  - Conduct Evaluations and Research Projects. NCH data may be utilized in ongoing research and evaluation projects.
  - Risk Adjustment Process. NMUD data is utilized in the Risk Adjustment System (RAS).
  - Appeals Process. NMUD data is utilized by Medicare Appeals System (MAS) for tracking appeal cases.
  - Call Center Claim Inquiry Process. NMUD data is utilized to support call center operations by making the claims data available via the Next Generation Desktop (NGD) utilized by call center employees.
  - Conduct Demonstrations Process. NMUD data may be utilized in ongoing demonstration for planning and implementation.

System Impacts

- NMUD contains claims data from 1998 to present and stores ICD-9 coded data. NMUD will require modification to store both ICD-9 and ICD-10 codes. There will not be a crosswalk of the data to convert older claims with ICD-9 to ICD-10 format. Claims will be stored with their original diagnosis and new claims (post-transition) will be stored with ICD-10 codes. NMUD will be required to store both formats. This impact is ***modest***[17]**.** NMUD is a relational database providing standard methods to update and to modify fields and field sizes.
- The staff supporting NMUD may require training to understand ICD-10 codes and the differences between the ICD-9 and ICD-10 to properly plan and implement the necessary changes to NMUD. This impact is ***minor*****.** The ICD-10 changes will be focused on expanding the field size for storage and for creating the necessary system outputs.

Integrated Data Repository

Description

Integrated Data Repository (IDR) is an enterprise data warehouse, integrating Medicare and Medicaid data, to facilitate CMS and CMS business partners' data access by providing a single source for data. The IDR is intended to provide a multi-centric view of the data encompassing beneficiary, claims, plan and clinical perspectives. The loading of data into the IDR is occurring in phases, starting with Medicare Part D data. IDR is currently the system of record for Medicare Part D data loaded from the Drug Database Processing System (DDPS). IDR contains Medicare Part A and B data from 2006 to present loaded from CWFMQA. The vision

[17] A Modest or Yellow Level Process will have an impact that, if the impact occurs, will cause small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

for IDR is to consolidate many of the existing systems supported by EDG. IDR contains ICD-9 coded data and is owned and maintained by OIS/EDG/DIDPM. IDR is not yet fully operational.

System Inputs

- IDR is loaded with Part A and B data from CWFMQA and stores ICD codes.
- IDR is loaded with Part D data from Drug Database Processing System (DDPS). This data does not contain ICD codes.

System Process

- IDR stores Part A and B claims data for 2006 to present.
- IDR stores Part D data.

System Outputs

- Currently, the IDR does not provide any outputs utilized by other systems or processes.

System Impacts

- The IDR data model will require updating to include the ICD-10 changes. The model will need to add additional elements and modify existing elements to support ICD-10. The level of effort to make these modifications in the IDR is considered minimal.

  The IDR currently loads Part A and B claims data from the NCH. The NCH system will be changing the claims format in support of ICD-10. These additional data elements and changes to existing data elements will trigger changes to the IDR Extract, Transform and Load (ETL) function. This will require the IDR to make programming changes to existing load streams and require testing of modified streams. The level of effort for these changes would be considered moderate.

  It is anticipated the IDR would have to load and maintain a crosswalk between ICD-9 and ICD-10 for analysis. The level of effort required to create and maintain the crosswalk would be moderate.

In the future, there are plans to add reporting and business intelligence to the IDR utilizing ICD-9. Currently, there is limited reporting. However, this is expected to change over the next several years as users become more familiar with the data in the IDR. It is expected that ICD-9 usage will increase significantly over the next several years as Parts A and B data are integrated with Part D drug data.

The IDR will require the modifications listed above to accommodate ICD-10 codes, while continuing to store ICD-9 codes. This impact is ***medium***. Field sizes storing diagnosis and procedure codes will require expansion to store ICD-10 codes and new

elements will be added. ETL functions will require programming changes to support ICD-10 codes and IDR will need to maintain a crosswalk for analysis.

Medicaid Statistical Information System (MSIS)

Description

MSIS is the basic source of state-submitted eligibility and claims data for the Medicaid population, their characteristics, utilization, and payments. States are required to submit all eligibility and claims data to CMS on a quarterly basis through the Medicaid Statistical Information System (MSIS). MSIS contains ICD-9 diagnosis and procedure codes. MSIS is owned by the Center for Medicaid State Operations (CMSO) / Finance, Systems, and Budget Group (FSBG) and maintained by OIS/EDG/DIDPM.

MSIS is described in detail in the Medicaid Policy and Medicaid Operations Process Detailed Summary.

System Files built from CMS Primary Repositories (not exhaustive)

- Medicare Provider Analysis & Review (MedPAR) File
- Standard Analytical Files (SAF) from NCH and NMUD
- National Claims History Summary (NCHSUM)
- Monthly Bill and Payment Records Processing (MBPRP) System
- National Claims History Statistical Tabulation System (NCHSTS)
- Healthcare Information System (HCIS) Data File
- Part B Extract and Summary System (BESS)
- Medicare Actuarial Data System (MADS)
- NCH TAP Files

Medicare Provider Analysis & Review (MedPAR) File

Description

The MedPAR File is a representation of a beneficiary's stay in a hospital or skilled nursing facility (SNF), and therefore contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and SNFs. The MedPAR File allows researchers to track inpatient history and patterns/outcomes of care over time. MedPAR File is aggregate data from multiple sources, including data from NCH and Supplemental Security Income (SSI) data from the Social Security Administration. MedPAR is built on a quarterly basis and contains data from 1991 to the present. MedPAR does contain ICD-9 coded data and is owned and maintained by OIS/EDG/DIDPM. The process for building the MedPAR File is not only contains extracted data, but also includes the comparison of and calculations with that extracted data. Thus, MedPAR is a data file as well as a set of programs.

System Inputs

- The MedPAR file is built quarterly with the following data:
  - Claims data from the NCH Inpatient/SNF TAP File. This file contains ICD codes.
  - Information from Health Insurance Skeleton Eligibility Write-Off (HISKEW) File from Office of Research, Development and Information (ORDI), which is pulled from the Enrollment Database (EDB). The HISKEW file is provided quarterly and yearly and contains date of death for beneficiaries. The HISKEW File does not contain ICD codes.
  - Supplemental Security Income (SSI) data from the Social Security Administration. SSI data is provided yearly and does not contain ICD codes.

System Process

- The process for building the MedPAR File is not only the extraction of data, but, also, includes comparing data in other CMS systems (enrollment data) and performing calculations.
- MedPAR system processes the data from NCH, HISKEW and SSA to combine claims to build a stay record. The algorithm references MS-DRGs, not ICD codes, but the ICD codes are in the MedPAR output file. MedPAR File contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and Skilled Nursing Facilities (SNF).

System Outputs and Uses

- The MedPAR File is utilized by researchers to track inpatient history and patterns/outcomes of care over time.
- Data from the MedPAR File is utilized by CMM to build the Transparency Report and used to populate the Hospital Compare site. The transparency reports are used to make cost and quality data available to all Americans. There are currently four reports on the CMS website. The current data is from fiscal year 2006. In 2007, CMM will no longer capture the Inpatient data since this information is now available on the Hospital Compare website. Transparency reports and the Hospital Compare site are derived from the MedPAR file. The ICD-9 codes are not captured in the Inpatient transparency or Hospital Compare information. The remaining transparency tables include Ambulatory Surgical Center (Carrier File), Hospital Outpatient (Outpatient File) and Physician Services (Carrier File).
- One of the MedPAR files (Expanded Modified MedPAR File) is used by CMM for rate setting and contains ICD codes.
- The MedPAR File is used by CMM to construct the MedPAR (DSH) file, which determines a hospital's adjustment for treating a disproportionate share of low-income patients. MedPAR DSH does not contain ICD codes.
- MedPAR provides data to the following processes:
  - Conduct Research Process, Collect and Publish Medicare Statistics Process. MedPAR File data is used to build the Annual Person Summary (APS), which is

used to build the tables in the Medicare Statistical Supplement. This involves ICD codes.

- Develop and Implement Payment Policy. CMS refines Medicare payment policy through annual rulemaking and responds to changes in clinical practice and industry operations.

System Impacts

- MedPAR System processes the data from NCH, HISKEW and SSA to combine claims to build the MedPAR File. The processing to create MedPAR file utilizes MS-DRGs, not ICD codes. The MedPAR File does contain ICD-9 codes and will to be required to accommodate ICD-10 codes. However, the modifications for the MedPAR programs will be focused on changes to utilize existing and new MS-DRGs implemented with the transition to ICD-10. In addition, the MedPAR File will have to accommodate the expanded field size of ICD-10 codes for storage. This impact is ***medium*.**

- The staff supporting MedPAR may require training to understand ICD-10 codes and the differences between ICD-9 and ICD-10 to properly plan and implement the necessary changes to MedPAR. This impact is ***minor*.** The ICD-10 changes will focused on expanding the field size for storage and for creating the necessary system outputs.

Standard Analytical Files from NCH and NMUD

Description

The Standard Analytical Files (SAFs) are generated by processing claims data from the NCH and NMUD through the final action algorithms. SAF processes claims data to match the original claim, with any claim adjustments, to show the claims final settlement at that time of processing. SAFs are available for each institutional claim type (inpatient, outpatient, SNF, hospice, or HHA) and for Non-institutional files (Carrier, DME) beginning with 1998. The record unit of SAFs is the final action claim (some episodes of care may have more than one final action claim). The NCH SAFs are created each quarter, but a given service year SAF is created over an 18-month timeframe. For example: service year 2007 SAF will become static in June of 2008 (18-months) The files are annual. SAFs are available as 5% sample copies or 100% of the data. SAF is owned and maintained by OIS/EDG/DIDPM.

List of SAFs (available in 100% and 5% samples)

- Inpatient SAF
- Skilled Nursing Facility SAF
- Outpatient SAF
- Home Health Agency SAF
- Hospice SAF
- DEMPOS SAF
- Clinical Lab SAF

System Inputs

- SAFs are built from NCH and NMUD data.
- SAFs are populated with data from NCH, specifically the following TAP Files.
  - 5% SAF TAP File
  - DMEPOS TAP File
  - RIC V/W TAP File (Institutional Claims)

System Process

- SAFs are final action claims level files where all claims adjustments are taken into account.

- SAFs have the same structure/format as NCH. Data are organized at the claim level and include basic beneficiary demographic information, date of service, diagnosis and procedure code, provider number, and reimbursement amount.

- Processing to build SAF file does not focus on ICD codes. ICD codes are passed from the raw claims data in NCH and NMUD to the SAFs. SAFs contain ICD codes.

System Outputs

- SAF data is accessed by Healthcare Information System (HCIS) Data File. HCIS provides summarized data from the Standard Analytical Files.
- SAF data is accessible via the Data Extract System (DESY) to accommodate data requests.
- Link to the following processes:
  - Conduct Research - Collect and Publish Medicare Statistics Process. SAF data is utilized to build Annual Person Summary and Catastrophic File System.
  - Conduct Demonstrations Process. SAF data may be utilized in ongoing demonstrations for planning and implementation.

System Impacts

Standard Analytical Files contain ICD codes and will have to store both ICD-9 and ICD-10 codes following the transition to ICD-10. SAFs are final action claims level files where all claims adjustments are taken into account and SAFs are usually available 9 months after the close of the calendar year. SAF data for the first year of the transition will have ICD-9 and ICD-10 codes with the transition planned for the fiscal year. This impact is ***modest.*** ICD codes are only passed through original data sources NMUD and NCH and not used in the processing of the data to create the SAF. SAF will have to store the expanded ICD-10 codes, as well as, maintain records with ICD-9 codes.

National Claims History Summary

Description

NCH Summary (NCHSUM) is individual line item files for Medicare Part B services and summarizes various pieces of information to feed the Part B Extract and Summary System (BESS). NCHSUM is built by CWFMQA on a monthly basis. NCHSUM is owned and maintained by OIS/EDG. NCHSUM is also known as Record Identification Code (RIC) O and M, Carrier, and DMERC File.

System Inputs

- NCHSUM is built from Medicare Part B (Carrier and Durable Medical Equipment (DME)) claims data pulled by CWFMQA from the data provided by CWF.

System Process

- NCHSUM creates individual line item files for Medicare services and summarizes various pieces of information from Part B claims data. NCHSUM is an intermediary data file used to build the Part B Extract and Summary System (BESS). BESS will not be transitioned to ICD-10, instead the system will be replaced by Part B Analytics File.

System Outputs

- NCHSUM data feeds to BESS. BESS provides data used to evaluate Part B procedures, monitor contracting, allocate resources, prepare impact statements, and develop budget and legislative proposals, congressional reports, and medical reviews. BESS is owned and maintained by Center for Medicare Management (CMM).

System Impacts

- NCHSUM contains ICD 9 codes and will contain both ICD-9 and ICD-10 codes, following the transition to ICD-10. NCHSUM will be required to accommodate the extended field size of ICD-10 codes. This impact is modest.
    - OIS/EDG will need to determine methods of trending or summarizing data with two coding standards when implementing changes to NCHSUM. This impact is modest. The data being summarized may span over multiple years. Although a crosswalk/mapping exists, there is not a one to one correlation between the two ICD coding classifications. ICD-10 is expanded to accommodate specificity and granularity of disease processes.

Monthly Bill and Payment Records Processing System

Description

Monthly Bill and Payment Records Processing (MBPRP) System is created by CWFMQA from data provided by CWF, on a monthly basis. MBPRP creates a collection of output files for down-line analytical processing, including development of the NCHSTS. MBPRP contains ICD codes. MBPRP is owned and maintained by OIS/EDG.

System Inputs

- The input to the MBPRP is institutional claims data extracted monthly and quarterly from CWFMQA weekly file.

System Process

- CWFMQA processes the Medicare Quality Assurance (MQA) 100% Intermediary claims and 100% payment record files on a monthly basis and creates a collection of output files for down-line analytical processing. Part A and Part B institutional claims data is used to create skeleton files used for analysis.

System Outputs

- MBPRP file is utilized to build the National Claims History Statistical Tabulation System (NCHSTS).
- MBPRP file are used by CMM.

System Impacts

- MBPRP contains ICD 9 codes and will contain both ICD-9 and ICD-10 codes, following the transition to ICD-10. MBPRP will be required to accommodate the extended field size of ICD-10 codes. In addition, MBPRP contains multiple years worth of data and the differences between ICD-9 and ICD-10 will need to be resolved when looking across multiple years of information. This impact is ***modest***.

National Claims History Statistical Tabulation System

Description

National Claims History Statistical Tabulation System (NCHSTS) is created by CWFMQA from files from MBPRP. NCHSTS contains statistical tabulations compiled on a quarterly and semi annual basis, looking at data over 7 years. NCHSTS summarizes and computes Medicare statistical tabulations related to beneficiary utilization. Statistics include the monitoring of claims payments across all carrier and intermediary submissions, the production of annual statistics/pamphlets by CMS, and the role of claims payments/reimbursements from an

economic analysis or perspective. The data concern reimbursements, charges, and length of stay. There are no impacts, since NCHSTS does not contain ICD codes. NCHSTS is owned and maintained by OIS/EDG.

System Inputs

- NCHSTS is created by CWFMQA using Medicare Part A data from the MBPRP.

System Process

- Statistical tabulations are compiled on a quarterly and semi annual basis, looking over 7 years of Part A data. NCHSTS summarizes and computes Medicare statistical tabulations related to beneficiary utilization. The data is related to reimbursements, charges, and length of stay.

Outputs

- NCHSTS tables are used by Office of Actuary (OACT), and other entities at CMS, for various statistics across a maximum of 7 calendar and fiscal years by state, national, or other criteria.

Impacts

- NCHSTS does not store ICD codes; however the process for building and calculating the information for NCHSTS will have to accommodate any changes in the data provided by MBPRP, as that system is transitioned to store and use ICD-10 codes. This impact is ***minor***.

Healthcare Information System Data File

Description

Healthcare Information System (HCIS) Data File is summarized data from the SAF. HCIS Data file is accessible using the HCIS application providing an easy-to-use access path for non-programmers to manipulate Medicare data into information. HCIS application allows users to sift through summarized Medicare information, in predetermined views, and to focus analysis on areas of suspected fraud and abuse in the Medicare program. HCIS Data File owned by Office of Financial Management (OFM)/Program Integrity Group (PIG) and maintained by OIS/EDG.

System Inputs

- HCIS Data File is built from data from the Standard Analytical Files

System Process

- HCIS Data File contains Medicare Part A (Inpatient, Skilled Nursing Facility, Home Health Agency (Part A & B) and Hospice) and Medicare Part B (Outpatient) based on the type and State of the institutional provider.

System Outputs

- Researchers use HCIS application to pull data from the HCIS data file
- Medicare Integrity Operations– Perform Data Analysis Process utilizes data from the Healthcare Information System (HCIS).

System Impacts

- HCIS Data File contains ICD codes and will need to store ICD-9 and ICD-10 codes following the transition to ICD-10**.** This impact is ***modest.***
- HCIS summarizes claims data providing summaries of diagnoses. HCIS summaries are calculated on a calendar year. For the first year of the transition, the data will be collected and summarized in both ICD formats with the transition planned for start of the fiscal year. This impact is ***modest.***

Part B Extract and Summary System

Description

Part B Extract and Summary System (BESS) provides data used to evaluate Part B procedures, monitor contracting, allocate resources, prepare impact statements, and develop budget and legislative proposals, congressional reports, and medical reviews. BESS is owned by CMM and maintained by Provider Billing Group.

System Inputs

- NCHSUM is an intermediary data file used to build the Part B Extract and Summary System (BESS)

System Outputs

- BESS provides data to Focused Medical Review (FMR) Reports
- Medicare Integrity Operations– Perform Data Analysis Process utilizes data from Part B Extract and Summary System (BESS).

System Impacts

- There is a part of the BESS system which relates procedures to diagnosis; however this portion of BESS will not be updated after 2008. This portion of BESS will not

be carried over to Part B Analytics (which is replacing BESS). Since the portion of BESS utilizing ICD codes will no longer be maintained after 2008, the transition to ICD-10 will not affect either BESS or Part B Analytics. There is no ***impact***.

Medicare Actuarial Data System

Description

Medicare Actuarial Data System (MADS) is built from a NCH TAP file (skeleton 100% TAP File), Part A deductible and Part B Premium reports and produces a set of tables used by the actuary for reporting these rates. MADS is a legacy system that will include only static data once the reports are transitioned to the IDR before the end of 2008. MADS will no longer be refreshed with current data since the reports will come directly from the IDR. At that point MADS will be maintained only as required by the business owner until it can be retired.

System Impacts

- MADS will no longer be refreshed with current data since the reports will come directly from the IDR. There is ***no impact.***

NCH TAP Files (Multiple data extracts for NCH)

TAP files are data extracts from National Claims History file. TAP files allow easier access to claims data compared to requesting data directly from NCH file. TAP claims data have the advantage of being available on a more-timely basis than data from the National Claims History file. TAP files are built monthly by NCH. Listed below are the NCH TAP files.

100% Nearline Monthly File

Description

- 100% Nearline Monthly File contains 100% of claims data in NCH. It is also known as the Program Integrity (PI) TAP file, since the file is utilized by the Program Safeguard Contractors. 100% Nearline Monthly File is also utilized by Recovery Audit Contractors (RACs) to examine claims for over or under payments. OIS\EDG\Division of Business Analysis & Operations (DBAO) and Division of Information Reporting Services (DIRS) utilize this file to respond to data requests.

Impact

- 100% Nearline Monthly File contains claims data, therefore, contains ICD codes. For the transition to ICD-10, the file format will require change to accommodate ICD-10 field length, as well as, continue to store ICD-9 codes. In the process of building the file, there is no processing of the ICD codes. The impact is ***minor.***

Part A (PTA)-Skeleton File

Description

- PTA Skeleton is built monthly from NCH and contains Part A claims. The PTA Skeleton file is used by the Office of the Actuary.

Impact

- PTA Skeleton contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the PTA Skeleton file does not utilize ICD codes. The impact is ***minor.***

Record Identification Code (RIC) V/W (Institutional Claims, Part A & B) TAP File

Description

- Record Identification Code V/W TAP File is built from NCH and contains all Part A and Part B Institutional claims. The Record Identification Code (RIC) V/W is used to build some of the Standard Analytical Files.

Impact

- Record Identification Code V/W TAP File contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the RIC V/W file does not utilize ICD codes. The impact is ***minor***.

Ambulatory Surgical Center (ASC) TAP File

Description

- Ambulatory Surgical Center (ASC) TAP file is built from Outpatient, Physician/Supplier and DMERC claims from NCH. The ACS TAP file is utilized to build some of the Standard Analytical Files and is used by ORDI and Office of Clinical Standards and Quality (OCSQ).

Impact

- ASC TAP File contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the ASC TAP File does not utilize ICD codes. The impact is ***minor.***

Inpatient/SNF TAP File

Description

- Inpatient/SNF TAP File is built from Inpatient and SNF Claims from NCH and is used to build the MEDPAR File. Inpatient/SNF TAP File is also used by ORDI and OCSQ.

Impact

- Inpatient/SNF TAP File contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the Inpatient/SNF TAP File does not utilize ICD codes. The impact is ***minor***.

5% TAP File (5% of all claim types—internal SAF use)

Description

- 5% TAP File is built from NCH claims data and is a random sampling of all claims types for 5% of the Medicare population. The 5% TAP File is used to build the 5% Standard Analytical Files.

Impact

- 5% TAP File contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the 5% TAP File does not utilize ICD codes. The impact is ***minor***.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) TAP File (RIC 'O' & 'M' – internal SAF use)

Description

- **DMEPOS TAP File** is built from DMEPOS and Physician/Supplier claims from NCH and is utilized to build some of the Standard Analytical Files.

Impact

- DMEPOS TAP File contains ICD codes and the file format will require change to accommodate ICD-10 field length. The process of building the DMEPOS TAP File does not utilize ICD codes. The impact is ***minor.***

Applications Utilized to Access Systems and Outputs

Data Extract System (DESY)

Description

DESY is owned and maintained by OIS/EDG. DESY provides an access path to CMS data. Several options are available through DESY for extracting complete files, as well as, subsets of the files. Record selections can be based on finder files of health insurance claim numbers, diagnosis codes, etc., as well as geographic conditions, or percentages. DESY provides the option of extracting only those fields necessary (a view) or the entire file. The data extracted may contain ICD-9 coded data.

DESY provides a graphical user interface and a programmatic interface for submitting and requesting data and contains an extraction component to process approved requests. DESY provides access to data from the following data sources, NCH, NMUD, SAF, MEDPAR, Denominator, and Name and Address/Vital Statistics. DESY's programmatic interface is utilized by the Recovery Management and Accounting System (ReMAS) to access claims data from NCH and NMUD to support the Medicare Secondary Payer Process.

Impact

DESY will require modification to accommodate ICD-10 codes and changes to its data sources (e.g., NCH, MEDPAR). The interfaces DESY provides may require change to accommodate ICD-9 and ICD-10 for data requests spanning the transition to ICD-10, as data sources, like NCH, will have both code sets. This impact is ***medium.***

Applications and Systems with No or Minimal Impacts

The following systems have no or limited impact related to the transition to ICD-10.

- MEDPAR Disproportionate Share Hospital (DSH)
    - MEDPAR (DSH) contains number of days for low income beneficiaries with both Social Security Income (SSI) and Medicare. MEDPAR (DSH) does not have ICD codes.
- Medicare Medicaid Cross Reference (MMX) alias Enterprise Cross Reference (ECR) system
    - MMX, also known as Enterprise Cross Reference (ECR), tracks Dual Eligibles between Medicare, Medicaid and Assisted Living and Dual Eligibles within the individual programs, e.g., who is getting benefits from more than one program and who the duplicates are within a program. MMX does not have ICD codes.
- Medicare Exclusion Database
    - Medicare Exclusion Database provides Medicare contractors a list of providers whose claims should be denied. There are no ICD Codes.

- Payment Withholding Database
    - Payment Withholding Database has been replaced by the Payment Withholding System. Payment Withholding Database tracked premium withholdings for Part D and does not have ICD codes.
- MicroStrategy/MIIR
    - Management Information Integrated Repository is focused on Part D Management Information. MIIR does not have ICD codes.
- DCEP Clinical Project
    - DCEP Clinical Project is related to clinical reports tied to Part D drug usage. These will reports will look at high risk medication use, drug-drug interaction reports, over-utilization reports, and adherence reports, etc. Currently, these reports to not link to Part A or Part B data and therefore do not have any diagnosis codes associated with them.
- Duplicate Payment System
    - Research was unable to uncover any contacts or current users for Duplicate Payment System. Based on this, there is believed this system is no longer being utilized by CMS.
- Enrollment Database (EDB)
    - Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment. EDB does not have ICD codes.
- Medicare Beneficiary Database (MBD)
    - Medicare Beneficiary Database (MBD)supports maintenance of the subset of Medicare data that documents both the insurance choices made by Medicare beneficiaries, and demographic information about the beneficiaries. The MBD does not use ICD Codes.
- Data Use Agreement and Data Shipping Tracking System (DADSS)
    - Data Use Agreement and Data Shipping Tracking System (DADSS) maintains a record of the Data Use Agreements (DUAs) for the release of claims data, but DADDS not sore ICD codes.
- Continuing Medical Education (CME)Tables
    - The CME tables contain mostly beneficiary-oriented data such as identification, name, address, demographics, eligibility, enrollment and the like, but do not include any ICD-9 data.
- Third Party System
    - The Third Party System is responsible for keeping track of Part A and Part B premiums that are paid by States or Private Third Party Groups or collected by OPM. The Third Party System does not use or store ICD codes.
- Medicare Incurred But Not Reported (IBNR) Claims
    - Medicare Incurred But Not Reported(IBNR) - is an estimate of the amount of claims that a managed care organization will need to pay for services rendered in that quarter for which it has not yet received claims.
- Adjusted Average Per Capita Cost (AAPCC)

- Adjusted Average Per Capita Cost (AAPCC) methodology - Under AAPCC, CMS projected average county-level fee-for-service spending for the coming year to set the reimbursement rates for Medicare health plans at 95 percent of the full AAPCC amount. This is an old methodology for determining rates.

Process Risk Assessment

The claims data stored in the CMS repositories provides Medicare data to a host of other systems and processes across the agency and to external entities. These repositories and data files built from claims data are utilized for policy determination, pricing determination, research, reporting and other vital CMS functions. CWFMQA provides the validation and formatting of claims data prior to loading into these repositories. Although, CWFMQA performs some quality and accuracy checks of claims data prior to storage in archive systems and or use in many downstream systems and processes, possible incorrect data, such as incorrect money amounts or codes, are not corrected by CWFMQA. CWFMQA, System Repositories and Data Outputs will require updating with the transition to ICD-10 to continue to support all of the uses of the CMS data.

CWFMQA

CWFMQA receives and processes claims containing ICD-9 coded data. CWFMQA performs edits on the claims data and will have to be able to process both ICD 9 and ICD 10 codes after the transition to ICD-10. The functions within CWFMQA will have to account for the expanded format of ICD-codes and the additional specificity of ICD-10. If the modifications of CWFMQA do not properly account for ICD-10 differences, CMS repositories may receive invalid or inaccurate claims data. CWFMQA will receive claims with ICD-9 and ICD-10 codes following the transition to ICD-10 and will need to maintain editing and validation functionality for both code sets. This risk is ***moderate*****.** Any errors in claims not discovered in the CWFMQA could result in errors in one of the many downstream repositories (NCH, NMUD, IDR), files (MedPAR, SAF) or processes (Risk Adjustment Process) relying on claims data sent from CWFMQA.

Primary CMS System Repositories

The CMS system repositories, National Claims History (NCH), National Medicare Utilization Database (NMUD), Integrated Data Repository (IDR) and Medicaid Statistical Information Statistics (MSIS) are the primary archiving systems for CMS providing policy makers and researchers access to Medicare and Medicaid claims history. All systems will need to allow for the storage of expanded ICD-10 codes and maintain the ability to store ICD-9 coded data. These repositories are the basis for all groups reviewing claims data to review existing programs and practices and to determine the future directions for Medicare and Medicaid. The

risk is ***medium*.** The inability to properly store and accommodate ICD-10 codes will limit CMS' ability to rely on claims history to review current activities and to plan for the future. In particular, NCH is an older system and CMS has limited staff to update and maintain this system. Any changes required to NCH will require more resources and planning to ensure successful updates.

Data Outputs built from CMS Repositories

The data outputs built from CMS Repositories support activities across the agency and provide data to external researchers and the general public. The data files can be simple extractions of data from a single source or in other cases are built through complex algorithms pulling multiple data sources internal and external to CMS. These data files provide support for research, fraud investigation, policy determination, pricing, and beneficiary customer service. The proper management of the transition to ICD-10 is vital to maintaining these data files as they support on-going CMS activities. Updates to these files will include expansion of field sizes to accommodate ICD-10 codes. In addition, for some data files detailed analysis of the use of ICD codes in the programming and algorithms will be required. If data files are not properly transitioned to include ICD-10 codes, many CMS downstream activities could be impacted. The risk is ***medium*[18].**

[18] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

Develop and Implement Payment Policy
Impact Rank: High

Table 11. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Develop and Implement Payment Policy: **High**[19]	Hospital and Ambulatory Policy Group (HAPG) ranking: High	Chronic Care Policy Group (CCPG) ranking: High	Provider Billing Group (PBG) ranking: High	Provider Communications Group (PCG) Ranking: Medium[20]	Medicare Contractor Management Group (MCMG) Division of Changes and Operations Management ranking: High	Office Information Services (OIS)/ Business Applications Management Group (BAMG) ranking: High
(Red)	(Red)	(Red)	(Red)	(Orange)	(Red)	(Red)

Process Overview

CMS refines Medicare payment policy through annual rulemaking and responds to changes in clinical practice and industry operations. This process is called Develop and Implement Payment Policy and has six process owners.

This document reflects the high-level processes that are performed by multiple CMS Groups/Divisions in order to operationally apply CMS healthcare coverage and payment policy into claims processing.

The Develop and Implement Payment Policy process is likely to have a ***high*** impact on the implementation of International Classification of Disease (ICD)-10, due to the varying levels and detail of ICD code use within each of the payment policies and interdependencies associated with other programs within CMS. ICD diagnosis codes are used to support most of CMS' benefit and coverage policies. This contributes to a number of areas CMS should consider for further analysis as they are identified as ***high*** impact or risk areas within the Develop and Implement Payment Policy process. All ranking definitions are defined in the appendix.

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[19] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.

[20] A Medium or Orange Level Process will have an impact that, if the impact occurs, will cause noticeable cost (and/or schedule) increases to the project.

The Develop and Implement Payment Policy process has the following component processes detailed in this report:

- Develop and Implement Acute Inpatient Payment Policy,
- Develop and Implement Ambulance Payment Policy,
- Develop and Implement Ambulatory Surgery Center Payment Policy,
- Develop and Implement Clinical Laboratory Payment Policy,
- Develop and Implement Durable Medical Equipment and Prosthetic Supplies Payment Policy,
- Develop and Implement ESRD Payment Policy,
- Develop and Implement Home Health Payment Policy,
- Develop and Implement Hospice Payment Policy,
- Develop and Implement Hospital Outpatient Payment Policy,
- Develop and Implement Long Term Care Payment Policy,
- Develop and Implement Physician Payment Policy,
- Develop and Implement Inpatient Psychiatric Facility Payment Policy,
- Develop and Implement Inpatient Rehabilitation Facility Payment Policy, and,
- Develop and Implement Skilled Nursing Facility Payment Policy.

Additionally the Provider Communications Group (PCG) has the following ***medium*** impact areas:

- FFS Contractor education and plan:
    - PCG will be tasked to work collaboratively with CMS components to prepare and deliver ICD-10 training to all FFS contractors.
- Provider Education:
    - PCG will provide high-level ICD-10 education and training to the providers via various multi-media as it pertains to the changes at the CMS program level. The providers will be expected, at their own expense, to obtain education and training on ICD-10 from external health information coding experts and industry product vendors as they do currently for ICD-9.
    - .PCG plans to develop and disseminate high-level ICD-10-CM and ICD-10-PCS materials, and we anticipate that the industry will continue to offer the more in-depth materials that specific stakeholder groups may need. We plan to continue to develop materials and resources as necessary in the future and will work with industry to facilitate additional outreach effort.
- Provider Call Center:
    - PCG estimates that they will need funding in order to cover the cost of increased provider calls related to ICD-10 program changes. PCG will also conduct extensive provider education on all payment policy changes as program instructions (e.g. IOMs and CRs) are issued.

The impact and risk areas are defined and organized by FFS payment policy in the process detail findings section below.

Process Owners

The six process owners for the Develop and Implement Payment Policy process are housed within the Center for Medicare Management (CMM) as follows:

- Hospital Ambulatory Policy Group (HAPG),
- Chronic Care Policy Group (CCPG) ,
- Provider Billing Group (PBG) ,
- Provider Communications Group (PCG),
- Medicare Contractor Management Group (MCMG).

The Office Information Services (OIS)/Business Applications Management Group (BAMG) is also involved in this process.

The process owners collaborate with various CMS components for the purpose of:

1. Developing and writing fee-for-service (FFS) payment policies and regulations,
2. Administering program requirements by creating claims processing instructions to FFS providers, suppliers and FFS Medicare Administrative Contractors (MACs),
3. Providing education relating to the program policies to FFS providers, suppliers and FFS MACs, and,
4. Implementing claims processing instructions and shared systems software specification changes.

Process Inputs

The CMM groups utilize many CMS input resources in the development of policy process which includes, but is not limited to obtaining data for use from:

- National Claims History (NCH),
- Prospective Payment System (PPS) Medicare Provider Analysis and Review (MedPAR) data,
- Standard Analytical Files (SAF),
- Various trending and analysis files/databases (ad hoc reports), and
- Center for Medicaid and State Operations (CMSO) Patient Assessment Instrument data entry systems:
    1. IRVEN,
    2. RAVEN, and,

3. HAVEN.

Most CMS FFS payment policies and regulations are updated or reviewed for update annually or as outlined in each specific payment policy process detailed findings section in this report. The process may include the issuance of a proposed rule in the Federal Register followed by the publication of a final rule announcing the final payment policies. In some instances where no annual policy changes occur, CMS may publish only a final rule announcing changes to payment rates.

CMS also issues a quarterly shared system release of program specification changes which are created by various CMS components utilizing the Change Management process. Any Medicare Program FFS shared systems changes are communicated by CMS components utilizing the Change Request/Change Management process via the Electronic Change Information Management Portal (eChimp). The shared systems change process is coordinated by the Medicare Contractor Management Group (MCMG) Division of Change and Operations Management (DCOM).

The accuracy of the instructional specification changes which contain International Classification of Disease (ICD) codes are of ***high*** impact and critical to provider billing for beneficiary services and the Office of Information Services (OIS) shared system updates which are utilized by the FFS contractors for claims processing. All ranking definitions are explained in the appendix and detailed in this report by process.

For a given fiscal year, the quarterly release schedule includes shared systems and claims processing specifications, including ICD codes, which occur on the first Monday of a quarter as follows:

- First Quarterly Release — On or about October 1,
- Second Quarterly Release — On or about January 1,
- Third Quarterly Release — On or about April 1, and,
- Fourth Quarterly Release — On or about July 1.

Develop and Implement Acute Inpatient Payment Policy

Process Detailed Findings

Table 12. Inpatient Prospective Payment System Rulemaking Time Table (Fiscal Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Fall/winter
Proposed rule publication	Late spring (April/May)
Comment period	Late spring - early summer
Final rule publication	On or about August 1
Final rule effective date	October 1

1. A Congressional Mandate requires an annual update of the DRG classifications and relative weights assigned to each DRG. The Hospital and Ambulatory Policy Group (HAPG), Division of Acute Care (DAC), is responsible for creating policy as required by this legislative mandate.

2. HAPG receives IPPS policy change requests in addition to the required annual update. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register*. Collaboration between the policy division in DAC and PBG results in on-going discussion during the required NPRM public comment period. After the public comments have been reviewed and considered, the Final Rule reflecting final policy changes or updates is published. There is constant communication between HAPG's DAC and PBG concerning policy implementation during this rule-making process. The NPRM and Final Rule policy changes and business requirements are sent through CMM for clearance.

3. Working together during the NPRM and Final Rule-making process, HAPG and PBG develop and refine specifications for payment. These specifications include updates for software and the value logic. Updates are posted to the CMS website at http://www.cms.hhs.gov when the final rule is published.

4. Updates are also made to the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded to the CMS website: http://www.cms.hhs.gov. The CMS website is utilized by industry stakeholders to access and review changes to payment policies. The website is updated by various components within CMS.

5. PBG creates and collaborates with the requisite PBG components on the Change Request (CR) process. The designated PBG component reviews the Final Rule and interprets the

policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the Medicare fee for service contractors.

6. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the coverage policy. The information to update and maintain the Medicare Code Editor (MCE), the Outpatient Code Editor (OCE), the MS-DRG Grouper, and the IPPS Pricer is included in this CR. The MCE, MS-DRG Grouper and the IPPS Pricer updates are effective with discharges on or after October 1. The OCE only receives the new ICD-code set updates in the October IPPS update. The OCE edits which are all outpatient edits are not altered until January with the OPPS rule update.

7. The updated table and files for acute inpatient payment policy are uploaded to the Fiscal Intermediary Shared System (FISS) Application Systems and are then accessible by the FISS contractors.

8. FISS contractors receive the CR and change the date schedule accordingly. FISS Contractors will install the software needed by the implementation date in order to access the data in FISS.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

FFS contractors will be required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to the ICD-10 implementation date CMM policy areas will work to create CRs detailing the necessary policy modifications with other CMS components to ensure a judicious implementation of ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing function there is a high impact if the CR specifications, edits and modifications are not done accurately, efficiently and in a timely manner. Any and all areas utilizing ICD-9-CM diagnosis and/or procedure codes will require the conversion to ICD-10-CM and/or ICD-PCS. The following list of Acute Inpatient Payment Policy areas will require updates.

Acute Inpatient Payment Policy – IPPS:

- Division of Acute Care (DAC)
  Hospital Acquired Condition Codes (HAC) Process (OCSQ/CMM/VBP)
- Acute Care Episode (ACE) Demonstration (current) (OCSQ/CMM/DAC)
- National Coverage Determinations Process (NCD) (OCSQ/CAG)

Process Risk Assessment

The Develop and Implement Acute Care Inpatient Payment Policy process and its associated sub-processes were found to have a ***high***[21] risk of disruption to the claims processing and quality activities if the transition to ICD-10 does not go well. The specific degree of risk was assessed based on detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases that are dependent on the accuracy of the content.

Develop and Implement Ambulance Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register*.

3. HAPG receives the Ambulance Payment Policy Requirement. Final rule requirements are passed along through HAPG.

4. The Payment Policy Requirement is sent to the requisite component in HAPG which accepts it and sends the final rule for payment requirements to PBG.

5. A component of HAPG receives these instructions. This component of HAPG sends the final rule payment requirements to PBG and CMS.hhs.gov.

6. Once an NPRM is accepted and the final rule is published, the Policy Groups develops and forwards specifications for payment. These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create/revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

[21] A High or Red Level Process will stop work or payment will cease at time of transaction.

9. PBG updates the Ambulance Fee Schedule. The table and files of the ambulance fee schedule are now accessible by the Multi-Carrier System (MCS) and the FISS Application Systems.

10. MCS and FISS Contractors receive the CR and change the date schedule accordingly. The MCS and FISS Contractors will install the changes to the fee schedule.

11. The updates to the ambulance fee schedule are installed and applied by the contractors to MCS and FISS. This is the only instance of duplicative fee schedule in the shared systems.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Reports and the Part B non-Institutional Claims Processing Summary Report contains the continuation of the above interdependent process including how the fee schedule and relevant modules are utilized by the MCS and FISS application.

Process Impact Assessment

The following Ambulance Policy areas have a ***minor***[22] impact:

Ambulance:

- Medical Conditions List,
    - CMS issued the Medical Conditions List as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While ICD codes are not precluded from use on ambulance claims, as they are currently not required per Health Insurance Portability and Accountability Act (HIPAA) on the ambulance claims, and these codes generally do not trigger a payment or a denial of a claim.

Process Risk Assessment

The Ambulance Policy process was found to have a ***minor*** risk of disruption to the claims process. This risk is due to the fact that ambulance claims are often done manually by the ambulance provider. These claims are likely to contain an ICD-9 code after implementation to ICD-10. Using ICD-9 codes after the transition occurs could lead to code error on the claim, but currently these errors do not trigger a payment or a denial of claim.

[22] A Minor or Green Level Process will continue with minimal or routine modifications to the process.

Develop and Implement Ambulatory Surgery Center Payment Policy

Table 13. Ambulatory Surgery Center Payment Rulemaking Time Table

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Winter/spring
Proposed rule publication	Summer (June/July)
Comment period	Late summer - early fall
Final rule publication	On or about November 1
Final rule effective date	January 1

1. The stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This process influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the Policy Group and published in the *Federal Register.*

3. Based on the comments to the NPRM, HAPG develops final Ambulatory Surgery Center Payment Policy to be published in the *Federal Register* as a final rule with comment period.

4. Once the final rule is published, the Policy Group develops and forwards specifications for payment. These specifications have updates for the MCS system.

5. At the same time, instructions are sent to create/revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

6. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions for the MCS contractors.

7. There are two activities in this process that occur simultaneously; during this activity, the CR specifies payment policy requirements and PBG is responsible for preparing the specifications for the requisite changes to the claims processing specifications.

8. The Change Request contains the necessary information to update and maintain the Ambulatory Surgical Center Fee Schedule (ASCFS) and ASC DRUG file.

9. The updated ASCFS and ASC DRUG file are uploaded to the MCS and are now accessible by the contractors.
10. Contractors receive the CR and will implement the required systems changes by the installation date.

The Claims Processing Part B MCS, CWF, and Crossovers Institutional Claims Summary Report contain the continuation of the above interdependent process.

Process Impact Assessment

Impact: ***No Impact.***

Ambulatory Surgical Center Payment Policy:

- ASC payment system has several hundred procedure classification groups with payment rates set using relative weights, a conversion factor, and adjustments for geographic differences. This payment system is not dependent on ICD codes for pricing, therefore reducing the impact to the policy.

Process Risk Assessment

The Ambulatory Surgical Center Payment Policy process and its associated systems were found to have a ***minor*** risk of disruption if the transition to ICD-10 does not go well. The specific degree of risk was assessed on the fact that ASC payment policy is based on CPT and HCPCS codes.

Develop and Implement Clinical Laboratory Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register.*

3. HAPG receives the Clinical Laboratory Payment Policy Requirement. Final rule requirements are passed along through HAPG.

4. The Payment Policy Requirement is sent to the requisite component in HAPG which accepts it and sends the final rule for payment requirements to PBG.

5. A component of HAPG receives these instructions. This component of HAPG sends the final rule payment requirements to PBG and CMS.hhs.gov.

6. Once an NPRM is accepted and the final rule is published, the Policy Groups develop and forward specifications for payment which are updated on a quarterly basis. These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the MCS contractors.

9. PBG updates the Clinical Laboratory Fee Schedule. The table and files of the clinical laboratory fee schedule are now accessible by the MCS Application Systems.

10. MCS Contractors receive the CR and change the date schedule accordingly. The MCS Contractors will install the changes to the fee schedule.

11. The updates to the fee schedule are installed and applied by the contractors to MCS.

The Part B non-Institutional Claims Processing Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

The Clinical Laboratory Payment Policy process and its associated sub-processes were found to have a ***high*** impact to claims processing if the transition to ICD-10 does not go well.

Clinical Laboratory:

- Clinical Lab Edit Table (OCSQ/Coverage and Analysis Group (CAG):
    - The CAG is responsible for the process of updating the ICD-9-CM codes found in the clinical laboratory (NCD) table. The nationally uniform software has been developed by Computer Sciences Corporation and incorporated in the shared systems which subject laboratory claims to one of the 23 laboratory NCDs. The laboratory edit module for the NCDs are updated quarterly as necessary to reflect coding updates and substantive changes to the NCDs developed through the NCD process. Every ICD-9-CM code falls into one of the three possible lists used in the edit module for the negotiated laboratory NCDs. During the transition to ICD-10-CM, the CAG will need to update the ICD-9-CM codes to ICD-10 to accurately represent the 23 NCDs within the table.

Process Risk Assessment

The Clinical Laboratory Payment Policy process and its associated sub-processes were found to have a ***medium*** risk of disruption to the claims processing if the transition to ICD-10 does not go well. The specific degree of risk was assessed based on detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases that are dependent on the accuracy of the content that represents the update to the clinical laboratory software quarterly.

Develop and Implement Durable Medical Equipment, Prosthetics, and Supplies (DMEPOS) Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Durable Medical Equipment and Prosthetic Supplies Policy NPRM and develops the final rule announcing the final policy.

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the CR to go out to the shared system maintainer (VMS) and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC). These specifications have updates for software and value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG updates any system changes for Durable Medical Equipment (DME), including fee schedule changes and new edits to ensure accurate payments, via the CMS quarterly

release. The table and files of the DME fee schedule are then accessible by the VMS Application Systems.

9. The VMS Contractors receive the CR and change the date schedule accordingly. The shared system maintainer (VMS) and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) will implement system changes, including to the DME Fee Schedule.

   The Claims Processing for Durable Medical Equipment Part B Claims Summary report includes information on how the fee schedule is utilized by the VMS application.

Process Impact Assessment

Impact: ***No impact.***

Process Risk Assessment

Impact: ***No risk.***

Develop and Implement ESRD Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed in collaboration with HAPG, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the ESRD Policy NPRM and develops the final rule announcing the final policy in collaboration with HAPG.

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare

Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage. The information to edit the Outpatient Code Editor and update and maintain the ESRD Pricer software is sent. The OCE edits which are all outpatient edits are not altered till January with the OPPS rule update.

10. The Change Request contains the necessary information needed to update and maintain the Outpatient Code Editor Software. This information is used to update the information used by the OCE module.

11. The Change Request contains the necessary information needed to update and maintain the ESRD Pricer Software. This information is used to update the information used by the ESRD Pricer module.

12. The updated table and files for ESRD payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

13. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

There is a ***minor*** impact to ESRD claims processing to ensure that the end-stage renal disease ICD-9 code is present. In order to keep claims processing and paying ESRD facilities, Pricer and Integrated Outpatient Code Editor (I/OCE) must be changed to reflect the parallel ICD-10 code or codes that indicate the patient has end-stage renal disease.

Process Risk Assessment

There is a clear one-time risk to ESRD payments associated with ICD-10 conversion. All ESRD claims are edited to ensure the current end-stage renal disease ICD-9 code is present. If, the system edit is not updated, no ESRD claims will be processed accurately. Once this change is made, there will not be on-going risk in the process.

Develop and Implement Home Health Payment Policy

Table 14. Home Health Agency Prospective Payment System Rulemaking Time Table (Calendar Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Winter/spring
Proposed rule publication	Summer (June/July)
Comment period	Late summer - early fall
Final rule publication	On or about November 1
Final rule effective date	January 1

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Home Health Payment Policy NPRM and develops the final rule announcing the final policy

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors and the CMSO.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage. Refer to the CMS list of HHRG with correlating list of Health Insurance Prospective Payment System (HIPPS) codes.

10. The CCPG component works with its contractor in the review of ICD-9-CM coding changes that may or may not affect the HH PPS, Grouper Software.

11. At the direction of CMS/CCPG, if deemed appropriate, the contractor updates, and/or performs maintenance on the HH PPS Grouper Software. The software specifications changes are used to update the information used by the Home Health Pricer module.

12. The FISS contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

13. The updated HH PPS Grouper Software, to include tables and files is uploaded to the HAVEN Application System as a module and are now accessible by the relevant stakeholders.

14. The Change Request also contains the necessary specifications needed to update and maintain the Home Health Pricer Software. This information is used to update the information used by the HH Pricer module.

15. The updated table and files for home health payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

16. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Please refer to the Develop and Utilize Assessment Tools – Claims Summary Report for the steps where the HAVEN System will provide a HIPPS code that is added to the Home Health Claims Record.

Process Impact Assessment

FFS contractors are required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to the ICD-10 implementation date, CMM policy areas will work to create CRs with the necessary policy modifications with PBG and other CMS components to ensure a judicious implementation to ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing process, there is a ***high*** impact if the CR specifications, edits and modifications are not done accurately, efficiently and in a timely manner. The following list of Home Health Payment Policy areas will require updates.

Home Health:

- OASIS Patient Assessment Instrument (QNHAG):
    - A nurse or therapist from the HHA uses the Outcome and Assessment Information Set (OASIS) instrument to assess the patient's condition.
- HAVEN Patient Assessment Instrument database (CMSO/FSBG),
- Home Health Resource Groups (HHRG) (case-mix group category) (CMM/CCPG):
    - OASIS items describing the patient's condition, as well as the expected therapy needs (physical, speech-language pathology, or occupational) are used to determine the case-mix adjustment to the standard payment rate. This adjustment is the case-mix adjustment. One hundred fifty – three (153) groups, or Home Health Resource Groups (HHRG), are available for patient classification.
    - CMM/PBG is responsible for defining HIPPS codes that correspond to these HHRGs, for use in claims processing.

The Develop and Utilize Assessment Tools – Claims Submission Process Summary Report has the step by step interdependencies where the HAVEN System will provide a HIPPS code that is added to the Home Health Claims Record.

Process Risk Assessment

There is an indirect risk to the Home Health Payment Policy as its dependencies (see above) that feed into it for data. The associated sub-processes were found to have a ***high*** risk of disruption to claims processing if the transition to ICD-10 does not go well. The detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases are dependent on the accuracy of the content that represents the update to the home health patient assessment and grouper. The specific degree of risk was assessed based on the fact that the downstream systems must also have a smooth implementation or there could be a significant slow down in claims processing.

Develop and Implement Hospice Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Hospice Payment Policy NPRM and develops the final rule announcing the final policy

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.HHS.gov. CMS.HHS.gov is available to the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage. The information to update and maintain the Outpatient Code Editor and the Hospice Pricer software is sent. The OCE edits which are all outpatient edits are not altered till January with the OPPS rule update.

10. The Change Request contains the necessary information needed to update and maintain the Outpatient Code Editor Software. This information is communicated and an update to the information used by the OCE module is made.

11. The Change Request contains the necessary information needed to update and maintain the Hospice Pricer Software. This information is used to update the information used by the Hospice Pricer module.

12. The updated table and files for hospice payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

13. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

    The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

There is only ***minor*** impact which exists for altering the NOE form to accept ICD-10 which is a component to the claims process, not the Hospice Policy process.

Hospice:

- Notice of Election (NOE) form,

  The NOE (an abbreviated claim) is submitted into FISS to notify the Medicare contractor, and the Common Working File (CWF) of the start date of the beneficiary's election to the hospice benefit. The claim page 03 on the NOE (Map 1713) contains payer information, ICD diagnosis/procedure code information, and physician information.

Process Risk Assessment

Impact: ***No risk.***

Develop and Implement Hospital Outpatient Payment Policy

Table 15. Outpatient Prospective Payment System Rulemaking Time Table (Calendar Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Winter/spring
Proposed rule publication	Summer (June/July)
Comment period	Late summer - early fall
Final rule publication	On or about November 1
Final rule effective date	January 1

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This process influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register.* There is a 60 day public comment period.

3. HAPG reviews the comments and secures policy decisions from CMS Management.

4. A component of HAPG drafts the final rule and necessary instructions for Medicare contractors. This component in HAPG sends the final rule payment requirements to PBG and CMS.hhs.gov.

5. Once the final rule is published, the Policy Groups develops and forwards specifications for payment. These specifications have updates for software and the value logic.

6. At the same time, instructions are sent to create/revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

7. HAPG and PBG create and collaborate with the requisite CMS components on the Change Request. The designated HAPG and PBG components receive the Final Rule and interpret the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

8. There are many activities in this process that occur simultaneously; during this activity, there are two CRs, one developed by HAPG that identifies the changes in OPPS payment policy for the new year and one developed by PBG that identifies the changes to the Integrated Outpatient Code Editor (I/OCE) for the new year. The information to

update and maintain the I/OCE and the Hospital Outpatient Pricer software is sent. The I/OCE edits which are all outpatient edits are not altered till January with the OPPS rule update.

9. The PBG CR contains the necessary information needed to update and maintain the I/OCE Software. This information is used to update the information used by the I/OCE module.

10. The HAPG CR contains the necessary information needed to update and maintain the Hospital Outpatient Pricer Software.

11. The updated table and files for hospital inpatient policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

12. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

    The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

The ***minor*** impacts noted below pertain to the Pricer and Outpatient Code Editor that would require field edit changes due to modifications and edits required within claims processing.

Hospital Outpatient:

- Partial Hospitalization for Psychiatric Services,
    - Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. The majority of payment policy related to Partial Hospitalization Program (PHP) is handled by CCPG/DCCM, which is responsible for payment policy of the PHP benefit, a structured program consisting of a group of mental health services paid on a per diem basis under OPPS. As part of the development of the OPPS rates, CCGP/DCCM is responsible for the PHP payment rate and related policies. Additionally, since PHP is the most intensive outpatient mental health treatment program, the PHP Ambulatory Payment Classification (APC) payment amount serves as a cap for all outpatient mental health services furnished in a day. PHP is paid under outpatient services Part B. ICD diagnosis codes apply for coverage of services.

- Integrated Outpatient Code Editor (I/OCE) for diagnosis codes validation.

Process Risk Assessment

Impact: ***No risk.***

Develop and Implement Long Term Care Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register.*

3. HAPG receives the Long Term Care Payment Policy Requirement. Final rule requirements are passed along through HAPG.

4. The Payment Policy Requirement is sent to the requisite component in HAPG which accepts it and sends the final rule for payment requirements to PBG.

5. A component of HAPG receives these instructions. This component of HAPG sends the final rule payment requirements to PBG and CMS.hhs.gov.

6. Once an NPRM is accepted and the final rule is published, the Policy Groups develops and forwards specifications for payment. These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage. The information to update and maintain the Medicare Code Editor, the Outpatient Code Editor, the MS DRG Grouper, and the LTC Pricer is sent. The OCE editor only receives the new ICD-code set updates in the October IPPS update. The OCE edits which are all outpatient edits are not altered till January with the OPPS rule update.

10. The Change Request contains the necessary information needed to update and maintain the Outpatient Code Editor Software. This information is used to update the information used by the OCE module.

11. The Change Request contains the necessary information needed to update and maintain the Medicare Code Editor Software. This information is used to update the information used by the MCE module.

12. The Change Request contains the necessary information needed to update and maintain the Diagnosis Related Grouper Software (MS DRG Grouper). This information is used to update the information used by the MS DRG Grouper Module.

13. The Change Request contains the necessary information needed to update and maintain the LTC Pricer Software. This information is used to update the information used by the LTC Pricer module.

14. The updated table and files for long term care payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

15. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

There is ***high*** impact to the Long-Term Care Hospital Payment Policy processes since the payment policy utilizes the IPPS MS-DRG Grouper, which will be updated with the Acute Care Inpatient policy.

Long-Term Care Hospital:

- MS-LTC-DRG Grouper Process (CMM/PBG)

Process Risk Assessment

Impact: ***No risk.***

Develop and Implement Physician Payment Policy

Table 16. Physician Fee Schedule including Part B Drugs Rulemaking Time Table (Calendar Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Winter/spring
Proposed rule publication	Summer (June/July)
Comment period	Late summer - early fall
Final rule publication	On or about November 1
Final rule effective date	January 1

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. HAPG is responsible for creating policy as required by these policy makers.

2. A notice of proposed rulemaking (NPRM) is developed by the policy group and published in the *Federal Register.*

3. HAPG receives the Physician Payment Policy Requirement. Final rule requirements are passed along through HAPG.

4. The Payment Policy Requirement is sent to the requisite component in HAPG which accepts it and sends the final payment rule on to the Department for approval and publishing as final in the Federal Register. Once the final rule is published, the Policy Group develops and forwards specifications for payment to the share systems maintainers through a CR. These specifications have updates for software and the value logic.

5. A HAPG component sends the final physician fee schedule rate updates to a PBG component to be put in a file format for release to the Medicare contractors and shared system maintainers.

6. At the same time, instructions are created based on new or revised policy changes in the final rule and the relevant sections of the Claims Processing Internet Only Manual (Publication 100-04) are updated. These change requests could contain new/revised diagnosis codes as depending on the policy change. The new updated instructions are posted for the public on the CMS web site after the final rule is published. The CMS web site (www.cms.hhs.gov) is accessed by the relevant stakeholders to view the new or revised changes in Medicare coverage and payment policies.

7. PBG creates and collaborates with the necessary CMS policy components on CRs associated with the Medicare Physician Fee Schedule Final Rule. The designated PBG

component works with the various policy components to develop and establish the necessary claims processing requirements needed to implement new policies based on the NPRM. The CRs instruct legacy FIs and carriers, A/B MACs and shared system maintainers on any necessary system changes that are required based on new or revised policies. The policy piece of the CRs could contain new or revised diagnosis codes.

8. PBG works with HAPG in order to implement the new Medicare Physician Fee Schedule rate and policy changes. The new physician fee schedule files containing the revised fees are made available by PBG for downloading by the shared system maintainers, (FISS and MCS) as well as the legacy contractors and the A/B MACs via PBG.

9. The file updates and policy changes via change requests are installed and implemented by the shared system maintainers, the legacy contractors and A/B MACs.

The Part B non-Institutional Claims Processing Diagram Summary report has the continuation of the above interdependent process on how the fee schedule is utilized by the MCS application.

Process Impact Assessment

Impact: There is a ***high*** impact to the Physician Payment Policy for required changes to the coverage and policy criteria which are based on the diagnoses on the claim.

Process Risk Assessment

Impact: The Physician Payment Policy process was found to have a ***high*** risk of disruption to the claims processing and quality activities if the transition to ICD-10 does not go well. The specific degree of risk was assessed based on detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases that are dependent on the accuracy of the content.

Develop and Implement Inpatient Psychiatric Facility Payment Policy

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Inpatient Psychiatric Facility Payment Policy NPRM and develops the final rule announcing the final policy

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage. The information to edit the MS DRG Grouper and the Inpatient Psychiatric Facility Pricer software is sent.

10. The Change Request contains the necessary information needed to update and maintain the Diagnosis Related Grouper Software (MS-DRG Grouper). This information is used to update the information used by the MS-DRG Grouper Module.

11. The Change Request contains the necessary information needed to update and maintain the Inpatient Psychiatric Facility Pricer Software. This information is used to update the information used by the Inpatient Psychiatric Facility Pricer module.

12. The updated table and files for Psychiatric Inpatient payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

13. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

The Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Summary Report contains the continuation of the above interdependent process.

Process Impact Assessment

FFS contractors are required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to the ICD-10 implementation date CMM policy areas will work to create CRs with the necessary policy modifications with PBG and other CMS components to ensure a judicious implementation to ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing process there is a ***high*** impact if the CR specifications, edits and modifications are not done accurately, efficiently and in a timely manner. The following list of Inpatient Psychiatric Facility Payment Policy areas will require updates.

Inpatient Psychiatric Facility Payment Policy:

- Co-morbidity adjustment diagnostic list (in Pricer),
- Co-morbidity adjustment procedure list (in Pricer),
- Co-morbidity worksheet (excel spreadsheet available on CMS.hhs.gov),
- Code First Table (in Pricer),
    - Official Coding Guidelines for ICD-10 have not been updated and finalized since 2003 to fully assess the impact on the code first table within the psychiatric pricer. Alterations to the guidelines may decrease or eliminate this sub-process.

Process Risk Assessment

The Develop and Implement Inpatient Psychiatric Payment Policy process and its associated sub-processes were found to have a ***high*** risk of disruption to the claims processing and quality activities if the transition to ICD-10 does not go well. The specific degree of risk was assessed based on detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases that are dependent on the accuracy of the content.

Develop and Implement Inpatient Rehabilitation Facility Payment Policy

Table 17. Inpatient Rehabilitation Facility Prospective Payment System Rulemaking Time Table (Fiscal Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Fall/winter
Proposed rule publication	Late spring (April/May)
Comment period	Late spring - early summer
Final rule publication	On or about August 1
Final rule effective date	October 1

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Inpatient Rehabilitation Facility Payment Policy NPRM and develops the final rule announcing the final policy

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is accessed by the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. PBG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors and the CMSO.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and CCPG/PBG is responsible for preparing the specifications for the requisite changes to the policy coverage.

10. The Change Request contains the necessary specifications or edits to be made in order to update and maintain the Case Mix Grouper Software. This information is used to update the information used by the IRF Grouper module.

11. PBG sends the specifications which include ICD codes that are aggregated by CMG. Refer to the list of CMG with correlating HIPPS codes. The CMSO updates and maintains the Case Mix Grouper Software.

12. The CMSO receives the CR and changes the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

13. The updated table and files for the Inpatient Rehabilitation Facility Grouper software is uploaded to the IRVEN Application Systems and are now accessible by the CMSO.

14. The Change Request also contains the necessary information needed to update and maintain the Inpatient Rehabilitation Facility Pricer Software. This information is used to update the information used by the Inpatient Rehabilitation Facility Pricer module.

15. The updated table and files for inpatient rehabilitation facility policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

16. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

    Please refer to the Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Diagram for an illustration on how these modules are utilized by the FISS application.

    Please refer the Develop and Utilize Assessment Tools – Claims Submission Summary Report for the interdependent processes where the IRVEN System will provide a HIPPS code that is added to the IRF Claims Record.

Process Impact Assessment

FFS contractors are required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to the ICD-10 implementation date CMM policy areas will work to create CRs with the necessary policy modifications with PBG and other CMS components to ensure a judicious implementation to ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing process there is a ***high*** impact if the CR specifications, edits and modifications are not done accurately, efficiently and in a timely manner. The following list of Inpatient Rehabilitation Payment Policy areas will require updates.

Rehabilitation – Inpatient:

- Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)/ Quality Measurement and Health Assessment Group (QMHAG):

- The IRF-PAI Impairment Group requires etiologic diagnosis input of an ICD code by the provider to indicate the condition requiring admission to rehabilitation. The impairment group code (IGC) is used to classify a patient into a Rehabilitation Impairment Category (RIC) which is the first level of classification for the case-mix grouper (CMG) 2.20. This ICD code and other co-morbid conditions listed in item 24 on the assessment tool are used in the CMG logic along with other clinical data to obtain the correct HIPPS code that is reported on the claim for determination of payment by the IRF Pricer.
- CMM/PBG is responsible for defining HIPPS codes that correspond to these CMG for use in claims processing.

- IRVEN (CMSO/FSBG):
    - IRVEN (Inpatient Rehabilitation Validation and Entry) system is a computerized data entry system for Inpatient Rehabilitation Facilities (IRFs). IRVEN offers users the ability to collect the IRF Patient Assessment Instrument (IRF-PAI) which includes ICD diagnoses codes in a database and creates a file in CMS-standard format that can be electronically transmitted to the IRF-PAI National database. The data collected is used for assessing the clinical characteristics of patients in rehabilitation hospitals and rehabilitation units in acute care hospitals. It includes a data dictionary and the case-mix grouper calculation which contains ICD codes.
- Case-mix groups – Rehabilitation Impairment Groups (RICs) (CMM/CCPG):
    - Appendix B – ICD Codes Related to Specific Impairment Groups IRF-PAI Training Manual (4/01/04),
    - Appendix C – List of Co-morbidities IRF-PAI Training Manual (4/01/04).

Process Risk Assessment

There is an indirect risk to the Inpatient Rehabilitation Payment Policy as its dependencies (see above) that feed into it for data. The associated sub-processes were found to have a ***medium*** risk of disruption to claims processing if the transition to ICD-10 does not go well. The detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases are dependent on the accuracy of the content that represents the update to the rehabilitation patient assessment and grouper. The specific degree of risk was assessed based on the fact that the downstream systems must also have a smooth implementation or there could be a significant slow down in claims processing.

Develop and Implement Skilled Nursing Facility Payment Policy

Table 18. Skilled Nursing Facility Prospective Payment System Rulemaking Time Table (Fiscal Year Cycle)

Rulemaking Phase	Approximate Timeframe
Proposed rule development	Fall/winter
Proposed rule publication	Late spring (April/May)
Comment period	Late spring - early summer
Final rule publication	On or about August 1
Final rule effective date	October 1

1. The external stakeholders that initiate the Payment Policy process do so through a CMS Policy Initiative, a Congressional Mandate or through Executive fiat. This legislation influences the payment decision and claims processing process. CCPG is responsible for developing policy as required by these policy makers and through the rulemaking process.

2. CCPG performs an analysis of the impact that any payment policy changes may have on the payment system, including changes to patient coding.

3. A notice of proposed rulemaking (NPRM) is developed by the policy group, vetted throughout CMS, and upon internal CMS clearance and Departmental approval, the NPRM is published in the *Federal Register* and on CMS.hhs.gov.

4. CCPG receives comments on the Skilled Nursing Facility Payment Policy NPRM and develops the final rule announcing the final policy

5. Upon internal CMS clearance and Departmental approval, the final rule is published in the *Federal Register* and on CMS.hhs.gov.

6. Once the final rule is published, CCPG prepares a written policy statement and, upon receipt of the policy statement, PBG writes the business requirements for the change request (CR) to go out to the shared system maintainers and the Medicare Administrative Contractors (MACs). These specifications have updates for software and the value logic.

7. At the same time, instructions are sent to create / revise the relevant sections in the Claims Processing Internet Only Manual (IOM) 100-04. These updates are then periodically uploaded for the necessary changes to CMS.hhs.gov. CMS.hhs.gov is available to the relevant stakeholders to access changes to payment policies. The web-site is updated by various components within CMS.

8. CCPG creates and collaborates with the requisite PBG components on the Change Request. The designated PBG component receives the Final Rule and interprets the policy requirements and payment specifications for creation of a CR representing billing and claims processing instructions to the FISS contractors and the CMSO.

9. There are many activities in this process that occur simultaneously; during this activity, the CR specifies coverage requirements and PBG is responsible for preparing the specifications for the requisite changes to the policy coverage.

10. The Change Request (CR) contains the necessary edits to be made in order to update and maintain the Skilled Nursing Facility Grouper Software. This information is used to update the information used by the Skilled Nursing Grouper module.

11. PBG sends the specifications which include ICD codes that are aggregated by RUG. Refer to the list of RUGs with correlating HIPPS codes. The CMSO updates and maintains the Case Mix Grouper Software.

12. The CMSO sets the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

13. The updated table and files for the Skilled Nursing Facility Grouper software is uploaded to the RAVEN Application Systems and are now accessible by the relevant stakeholders.

14. The Change Request also contains the necessary information needed to update and maintain the Skilled Nursing Facility Pricer Software. This information is used to update the information used by the Skilled Nursing Facility Pricer module.

15. The updated table and files for skilled nursing facility payment policy are uploaded to the FISS Application Systems and are now accessible by the FISS contractors.

16. FISS Contractors receive the CR and change the date schedule accordingly. FISS Contractors will implement the software needed by the installation date in order to access the data in FISS.

    Please refer to the Claims Processing Part A and B FISS, CWF, and Crossovers Institutional Claims Diagram for an illustration on how these modules are utilized by the FISS application.
    Please refer to the Develop and Utilize Assessment Tools – Claims Submission Process for the step where the RAVEN System will provide a HIPPS code that is added to the SNF Claims Record.

Process Impact Assessment

FFS contractors are required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to the ICD-10 implementation date CMM policy areas will work to create CRs with the necessary policy modifications with PBG and other CMS components to ensure a judicious implementation to ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing process there is a ***high*** impact if the CR specifications, edits and modifications are not done accurately, efficiently and in a timely manner. The following list of Skilled Nursing Facility Payment Policy areas will require updates.

Skilled Nursing Facility (SNF):

- Resource Utilization Groups (CMM/PBG):
    - The SNF PPS incorporates adjustments to account for facility case mix, using the system for classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG-III). Facilities will utilize information from the most recent version of the Minimum Data Set (MDS), to classify residents into the 53 RUG-III groups. The RUG-III 5.20 Grouper software program is used by providers to assign patients to an appropriate group based on the MDS 2.0 and available from many software vendors or the CMS Internet Web site. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare payment. The MDS 3.0 is slated for implementation in October 2009. For Medicare billing purposes, there is a non-ICD payment code (HIPPS) associated with each of the 53 RUG-III groups, which is applied by the provider on the claim which is active in the SNF pricer software. In addition, there is an ICD-9 code associated with the AIDS add-on payment applied by the SNF pricer software.
- RAVEN (CMSO/FSBG):
    - RAVEN uses a database of ICD-9-CM codes for reference in assisting users with the entry of ICD-9-CM codes into MDS 2.0 assessments.

Process Risk Assessment

There is an indirect risk to the Skilled Nursing Facility Payment Policy as its dependencies (see above) that feed into it for data. The associated sub-processes were found to have a ***medium***[23] risk of disruption to claims processing if the transition to ICD-10 does not go well. The detailed findings regarding the implementation of the change requests (CRs) and the dependencies of subsequent CMS processes and databases are dependent on the accuracy of the content that represents the update to the SNF patient assessment and grouper. The specific degree of risk

[23] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

was assessed based on the fact that the downstream systems must also have a smooth implementation or there could be a significant slow down in claims processing.

Develop and Support Quality Measures and Payment Initiatives
Impact Rank: High

Table 19. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Develop and Support Quality Measures and Payment Initiatives Process: High[24]	Office of Clinical Standards and Quality (OCSQ) / Quality Measurement and Health Assessment Group (QMHAG) / Division of Chronic and Post Acute Care (DCPAC): High	Office of Clinical Standards and Quality (OCSQ) / Quality Measurement and Health Assessment Group (QMHAG) / Division of Hospitals & Medication Measurement (DHMM): High	Office of Clinical Standards and Quality (OCSQ) / Quality Measurement and Health Assessment Group (QMHAG) / Division of Ambulatory Care & Measures Management (DACMM): High	Office of Clinical Standards and Quality (OCSQ) / Information System Group (ISG)/ Division of QIO Systems and Contract Management (DQSCM): High	Office of Clinical Standards and Quality (OCSQ) / Quality Improvement Group (QIG) / Division of Quality Improvement Policy for Acute Care (DQIPAC): Modest[25]
(Red Level)	Red Level)	(Red Level)	(Red Level)	(Red Level)	(Yellow Level)

Process Overview

There are four processes associated with the Develop and Support Quality Measures and Payment Initiatives:

- Quality Measures,
- Physicians Quality Reporting Initiative (PQRI) Payment Initiative
- Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Payment Initiative, and,
- Hospital Outpatient Quality Data Reporting (HOP QDRP) Payment Initiative

The Quality Measures process details the development, approval, and implementation of quality measures. Legislation, CMS initiatives, clinical relevance, and industry are the forces behind the creation and modification of quality measures. Quality measures are developed and used to measure quality with respect to numerous types of healthcare providers, physicians, and other professionals to ensure and improve the quality of care provided to all patients. ICD-9 codes are an integral element of the specifications and algorithms for the various quality measures. Once quality measures have been developed, they are entered into the Quality Measure Management Information System (QMIS). QMIS, an electronic database, is the

[24] A High or Red Level Process has the potential for significant cost (and/or schedule) increases to the project.
[25] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

repository for all Centers for Medicare & Medicaid Services (CMS) quality measures and the information on the quality measure including their technical specification, justification and history. The Quality Measurement & Health Assessment Group (QMHAG) of the Office of Clinical Standards and Quality (OCSQ) has oversight responsibility of the contractors who develop the various quality measures and manage QMIS. The quality measures are used for the PQRI, RHQDAPU, and HOP QDRP programs.

The PQRI program was established by CMS as a result of the 2006 Tax Relief and Health Care Act. The Medicare, Medicaid and SCHIP Act of 2007 extended CMS's authorization to make PQRI incentive payments for satisfactory reporting of quality measures data in 2008. For the PQRI program, eligible professionals can participate voluntarily. Those eligible professionals that satisfactorily report their PQRI quality measurement data will receive an incentive payment equivalent to 1.5% of their total allowed charges for Medicare Physician Fee Schedule (PFS) covered professional services furnished during that same reporting period. The Division of Ambulatory Care & Measures Management (DACMM) within QMHAG of OSCQ has oversight responsibility for the PQRI program. The PQRI Dimensional Database is the system used to receive, store and perform analysis on the PQRI quality measurement data. The data contained in the PQRI Dimensional Database is Part B claims data including ICD-9 codes, Current Procedural Terminology (CPT) Category II codes (performance measurement codes) and Healthcare Common Procedure Coding System (HCPCS) G codes. The Division of QIO Systems and Contract Management (DQSCM) within the Information System Group (ISG) of OCSQ owns and maintains this database.

The RHQDAPU program was initially established as a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and was further defined by the Deficit Reduction Act of 2005. The RHQDAPU program requires hospitals to voluntarily submit inpatient data for specific quality measures for health conditions common among people with Medicare. Hospitals participating in the RHQDAPU program and satisfactorily report their quality measurement data will receive their full Medicare Annual Payment Update (APU) for that fiscal year. Hospitals who do not participate in the RHQDAPU initiative or do not satisfactorily report their quality measurement data will receive a reduction of 2.0 % to their Medicare APU for that fiscal year. A primary goal of the RHQDAPU program is to provide consumers with quality of care information allowing consumers to make more informed decisions about their health care. Additionally, the RHQDAPU program encourages hospitals and clinicians to improve the quality of care provided to all patients. The hospital quality measurement data gathered and analyzed through the RHQDAPU initiative is posted on the Hospital Compare website. The Division of Hospitals & Medication Measurement (DHMM) within QMHAG of OCSQ has oversight responsibility of the RHQDAPU program. The RHQDAPU quality measures are also published in the web-enabled Specification Manual for National Hospital Inpatient Quality Measures. The Division of Quality Improvement Policy for Acute Care (DQIPAC) within the Quality Improvement Group (QIG) of OCSQ has oversight responsibility of this manual. The Clinical Data Warehouse receives stores and performs analysis on the RHQDAPU chart based measures. Additionally, files received from the National Claims History (NCH) system are used to perform analysis on the RHQDAPU

claims based measures. OCSQ/ISG/DQSCM owns and maintains the Clinical Data Warehouse.

The HOP QDRP initiative was outlined in the Outpatient Prospective Payment (OPPS) final rule published on November 1, 2007. Hospitals began collecting data on the outpatient measures in 2008. The HOP QDRP Program allows hospitals to voluntarily submit outpatient quality data. Hospitals satisfactorily reporting their outpatient quality measurement data will receive their full OPPS APU. OCSQ/QMHAG/DHMM has oversight responsibility of the HOP QDRP program. The HOP QDRD quality measures are also published in the web-enabled Specification Manual for Hospital Outpatient Department Quality Measures. OCSQ/QMHAG/DHMM has oversight responsibility of this manual. The OPPS Clinical Data Warehouse receives stores and analyses outpatient quality measurement data. OCSQ/ISG/DQSCM owns and maintains the OPPS Clinical Data Warehouse.

The primary impacts for the ICD-10 transition to the Quality Measurement process will be on updating the measures specifications and algorithms with ICD-10 codes. Although mapping between ICD-9 and ICD-10 exists, algorithms may be compromised as there is not a one to one correlation in all cases. Future consideration for more specific and accurate quality measures are made possible due to the increased specificity of ICD-10. Additionally, the QMIS database will need to be modified to accept ICD-10 codes.

The primary impacts for the ICD-10 transition to the various payment incentive programs will be reformatting of the PQRI Dimensional Database, Clinical Data Warehouse and the OPPS Clinical Data Warehouse to receive, store and analyze the expanded ICD-10 codes. The reformatting of these databases is crucial for the accurate calculation of providers' eligibility for incentive payments. Additionally, if the Clinical Warehouse does not accurately calculate performance rates for hospital inpatient measures, inaccurate performance rates will be posted on Hospital Compare Website. Consumers would then have inaccurate performance data to make decisions about their health care. The quality measurement data is also compared over time and the ability to analyze this trend data will be impacted by the differences between ICD-9 and ICD-10 including the level of specificity and differences in code composition.

Related Processes

The RHQDAPU Payment Initiative process within the Develop and Support Quality Measures and Payment Initiatives process is interrelated to the Support Quality Improvement Activities and ESRD Networks process.

The PQRI Payment Initiative process within the Develop and Support Quality Measures and Payment Initiatives process is interrelated to the Claims Processing – Part B – MCS, CWF process.

Quality Measures

1. The requirements for the development or need for quality measures are obtained from Congressional mandates and various CMS initiatives. The CMS initiatives are inputs from industry trends and interests, clinical relevance and quality improvement initiatives. Quality measures are developed and implemented to ensure that beneficiaries are receiving the highest level of medical care.

   Impact: ***No Impact.***

2. Measure needs are forwarded to OCSQ/QMHAG who will perform research or assessment on the availability of quality measures for proposed programs.

   Impact: ***No Impact.***

3. Quality measurement requirements or needs are forwarded by OCSQ/QMHAG to the measurement contractors who will develop quality measures, as appropriate. All three QMHAG divisions have oversight responsibility for the different quality measures. The Division of Chronic and Post Acute Care (DCPAC) has oversight responsibility for nursing home, home health agency and ESRD quality measures, Division of Hospitals & Medication Measurement (DHMM) for hospital inpatient chart abstraction and claims based quality measures and hospital outpatient quality measures and Division of Ambulatory Care & Measures Management (DACMM) for physician and non-MD-DO quality measures. Once developed, the quality measures including their specifications and algorithms are stored in the Quality Measure Management Information System (QMIS). QMIS, an electronic database, is the repository for all Centers for Medicare & Medicaid Services (CMS) quality measures and the information on the quality measure including their technical specifications including algorithms, justification and history. The quality measure specifications and algorithms contain ICD codes. Implemented measures include:

   - End Stage Renal Disease Measures,
   - Home Health Agency Measures,
   - Hospital Inpatient/Outpatient Measures which includes:
     - Chart Abstraction Measures, and,
     - Claims Based Measures;
   - Nursing Home Measures, and,
   - Physician and Non-MD - DO Measures.

   Impact:

   - The measurement contractors under the oversight of OCSQ/QMHAG will be responsible for updating the quality measures specifications and algorithms with ICD-10 codes utilizing the existing mappings. Measurement specifications and

- The QMIS database will require upgrading to accommodate ICD-10 codes. The existing mapping tools in QMIS will need to be reprogrammed and code to link codes to their respective description will require rewriting. OSCQ/QMHAG will be responsible for the oversight of its contractors performing the upgrade of the QMIS database. The impact is ***modest***.

PQRI (Physicians Quality Reporting Initiative) Payment Programs

1. The measurement contractor, under the oversight of OCSQ/QMHAG/DACMM, develops and publishes the physician and non MD-DO quality measures, guidelines and specification on the PQRI website. OCSQ/QMHAG/DACDM receives the quality measures and specifications, which are also published in QMIS, from the measurement contractor. Additional measures are provided by medical specialty organizations such as, but not limited to, the Society for Thoracic Surgery, Society for Vascular Surgery, American Podiatric Medical Association, the American Medical Association (AMA) and the National Committee for Quality Assurance (NCQA)

   Impact:

   - The PQRI clinically-related and structural measures contain ICD codes. ICD-9 codes along with CPT Category II codes and HCPCS G codes are used to identify and track submitted claims that are eligible for the PQRI program. If the transition from ICD-9 to ICD-10 is not performed accurately, the PQRI process may not be able to identify, track, and process submitted claims. Additionally, eligible professional's incentive payments could be impacted by a delay or miscoding of ICD codes during the transition. The impact is ***medium***[26].

   - Quality measures generated by external measure developers such as, but not limited to, the AMA and the NCQA will need to be transitioned to contain ICD-10 codes. As this process falls outside CMS, if the transition is not successful the quality measures developed by external measure developers, such as but not limited to, the

[26] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

AMA and the NCQA will not be included in the PQRI process. The impact is ***minor***[27].

2. Eligible professionals access the measures from the PQRI program website and identify measures they wish to report. Eligible professionals are defined as Medicare physicians, practitioners, and therapists. Medicare physicians are further defined as Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine and Chiropractor. Practitioners are further defined as physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician and nutritional professional. Therapists are further defined as physical therapist, occupational therapist and qualified speech-language pathologist. Eligible professionals submit claims containing one of the specific ICD-9 diagnosis codes along with the corresponding CPT II codes and/or HCPCS G codes. These codes identify the claims submitted as belonging to the PQRI program. Claims are submitted to the MAC and are processed as Medicare Part B claims. The submission of claims can be connected to Claims Processing - Part B - MCS, CWF process.

   Impact:

   - With the transition to ICD-10, eligible professionals will need to submit accurate ICD-10 codes on their claims. Eligible professionals will require ICD-10 training in order to accurately submit the appropriate ICD-10 diagnosis codes on their claims for inclusion in the PQRI program. The impact is ***medium***.

   - The claims processing systems will need to be modified to accept, load, adjudicate, and store claims using the ICD-10 format. The extensive number of systems and processes that would need to be modified to process claims containing ICD-10 codes makes the impact to this process ***high***.

   - If the PQRI program reporting cycle and the date for implementation of ICD-10 codes does not align, claims containing both ICD-9 and ICD-10 codes may be submitted. Part B claims processing would need to have the capability to process 2 code sets. The impact is ***modest***.

3. The analysis reporting contractor extracts PQRI program performance data from the PQRI Dimensional Database which is fed from the National Claims History (NCH). After claims are processed by the Common Working File at CMS, the Common Working File Quality Assurance (CWFMQA) loads claims data to NCH. The analysis reporting contactor identifies PQRI claims based on the attached CPT II codes and/or G codes on the claims. The interviewing process revealed there will be two additional

[27] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

feeds into the PQRI Dimensional Database sometime in early 2009. These two databases currently under development are the Registry Database and the Electronic Health Record (EHR) database.

Impact:

- The claims processing systems will need to be modified to accept, load, adjudicate, and store claims using the ICD-10 format. The extensive number of systems and processes needing to be modified to process claims containing ICD-10 codes makes the impact to this process ***high***.

- The PQRI Dimensional Database will need to be updated to accommodate ICD-10 data. OCSQ/ISG/DQSCM will be responsible for updating the PQRI Dimensional Database. The impact is ***minor***.

4. The analysis reporting contractor, using the PQRI Dimensional Database, will analyze the performance data. Analysis focuses on determining if eligible providers satisfactorily reported quality measures.

   Impact:

   - The PQRI Dimensional Database will need to be updated to accommodate ICD-10 data. The impact is ***minor***.

   - The analysis reporting contractor will require ICD-10 training in order to accurately analyze performance data after the transition to ICD-10. The impact is ***minor***.

5. The analysis reporting contractor will then calculate incentive payments for eligible professionals and forward the data concerning those eligible for incentive payments to the Provider Billing Group (PBG) within the Center for Medicare Management (CMM).

   Impact:

   - Incentive payment to eligible professionals relies on the successful identification and analysis of PQRI claims. Changes to the CWF and the PQRI Dimensional Database will need to be successful to ensure the accurate calculation and dispersal of the payment incentives. The impact is ***modest***.

6. CMM/PBG will receive and review the calculated incentive payment from the analysis reporting contractor.

Impact: ***No Impact.***

7. Once approved, the incentive payment is forwarded from CMM/PBG to the carrier/MAC for disbursement of incentive payment to the eligible professional.

Impact: ***No Impact.***

RHQDAPU (Reporting Hospital Quality Data for Annual Payment Update) Payment Initiative

1. The measurement contractor under the oversight of OCSQ/QMHAG/DHMM publishes the hospital RHQDAPU (hospital inpatient quality measures) measures, guidelines and specifications. These measures are published simultaneously to OCSQ/QIG/DQIPAC and QMIS.

Impact: ***No impact.***

2. The quality contractor, under the oversight of OCSQ/QIG/DQIPAC, receives the hospital inpatient quality measures and publishes them to the web-enabled Specification Manual for National Hospital Inpatient Quality Measures (specification manual). The Specification Manual, which contains ICD codes, is updated twice a year and is made available to providers on QNET. OCSQ/QIG/DQIPAC and its quality contractors collaborate with The Joint Commission (TJC) to publish the Specification Manual.

Impact:

- The quality contractor, under the oversight of OCSQ/QIG/DQIPAC, will be responsible for publishing the updated Specification Manual containing the measures algorithms and specifications that were rewritten by the measurement contractors to accommodate ICD-10. Currently the Specification Manual and the RHQDAPU are updated in April and October of each year. Hospitals submit their quality measure data on a quarterly basis. Consideration may need to be given regarding the publication of the Specification Manual if a version of the manual spans a time period where both ICD-9 and ICD-10 codes will be reported by the hospitals. The impact is ***minor***.

- The quality contractor will also be responsible for updating the coding tables contained within the Specification Manual with ICD-10 codes utilizing existing mappings. The quality contractors will require ICD-10 training in order to accurately update the codes. The impact is ***modest***.

3. Hospitals access the Specification Manual on QNET to obtain the hospital inpatient quality measures and their specifications. Using either the CMS provided CMS Abstraction and Reporting Tool (CART) or a commercial ORYX tool; hospitals collect and store their hospital inpatient quality measurement data. The measurement data

includes ICD codes. The hospitals that utilize the CART tool can also access the Specification Manual within CART

Impact:

- The CART tool supplied by CMS to store hospital inpatient quality measurement data will need to be updated to accommodate ICD-10 codes. OCSQ/ISG/DQSCM will be responsible for updating the CART tool. OCSQ/ISG/DQSCM will need to updated the CART and make it available for providers at least 6 months prior to the implementation date of ICD-10. The impact is ***minor***.

- If the RHQDAPU reporting cycle and the date for implementation of ICD-10 codes does not align, quality measurement data containing both ICD-9 and ICD-10 codes may need to be collected and stored within CART or ORYX and submitted. The impact is ***modest***

4. The quality contractor receives the hospital inpatient quality measurement data and stores it in the Clinical Data Warehouse.

Impact:

- The Clinical Data Warehouse will require system changes to allow for acceptance of the new ICD-10 codes. The database will need to be modified to increase the field length size of the code fields in addition to redevelopment of the analytic tools for the measures. Since there is a five month lag between the submission deadline and the data collection deadline, consideration will need to be made for the Clinical Data Warehouse to accept both ICD-9 and ICD-10 codes. This would result in both system and software changes being required to allow for parallel processing of both ICD-10 and ICD-9 codes in all programs where ICD-9 codes are currently stored, displayed, edited and reported. OCSQ/ISG/DQSCM will be responsible for making the modifications to the Clinical Data Warehouse to accommodate retrieving and storing ICD-10 codes. This impact is ***high***.

5. The quality contractor retrieves the hospital performance data from the Clinical Data Warehouse. Additionally, claims data is retrieved, using the Data Extract System (DESY) from NCH. Using both data sources, the quality contractor will validate satisfactory reporting of quality measurement data for each hospital. The numerator of this validation is the number of patients that the hospitals submitted quality data on per diagnosis or condition (Clinical Data Warehouse) and the denominator is the total patients with the same principal diagnosis or condition for the hospital (NCH). The validation step determines whether or not a hospital submitting quality measurement data on the correct number of patients. Additionally, a random sample of records is reviewed to validate the accuracy of the quality measurement data being submitted. This is accomplished by the quality contractor selecting a random sample of 5 records

per quarter and sending the information to the Clinical Data Abstract Center (CDAC). CDAC then requests the medical records from the hospitals and using the medical record validates if the quality measurement data submitted was accurate.

Impact:

- If either the Clinical Data Warehouse or NCH provides the quality contractor with inaccurate data as a result of the transition to ICD-10, the determination of whether or not a hospital satisfactorily reported their quality data would be inaccurate. This would result in one of two inaccuracies. First, a hospital could incorrectly be identified as not satisfactorily reporting their quality data resulting in the hospital not receiving their full APU which they would be entitled to. Second, a hospital could be incorrectly identified as satisfactorily reporting their quality data resulting in the hospital receiving their full APU which they were not entitled to receive. The impact is ***medium***.

- The validation of the accuracy of the submitted quality measurement data performed by CDAC involves the use of ICD codes and coding knowledge. The CDAC staff will require in-depth ICD-10 training in order that this validation process is accurate after ICD-10 implementation. The impact is ***minor***.

6. Upon completion of the validation of satisfactory reporting, the quality contractor will create a list of hospitals that meet the Annual Payment Update (APU) requirements. The list identifies the hospitals participating in the RHQDAPU initiative, satisfactorily reported their quality measurement data and eligible to receive their full Medicare Annual Payment Update for that fiscal year. Hospitals not on the list would receive a reduction of 2.0 percent in their Medicare APU for that fiscal year.

   Impact: ***No Impact.***

7. The list of hospitals meeting APU requirements is forwarded to OCSQ/QIG who will receive approval of the findings from the Administrator.

   Impact: ***No Impact.***

8. Once approved, the APU list is forwarded to CMM/PBG who will pass the results to the MAC for payment to the hospital.

   Impact: ***No Impact.***

9. As the process for determining hospitals satisfactorily meeting APU requirements is being performed, the quality contractor is simultaneously analyzing claims data for each hospital in order to determine the claims based quality measures performance rates for

inclusion in the Hospital Compare website. These claims based measures are mortality measures and claims data obtained from NCH is used to perform the calculations.

Impact:

- The process to calculate the performance rates will need to be updated to accommodate the use of ICD-10 codes in the process. The actual performance rates do not contain ICD codes but the information needed to determine the data eligible for calculation of the performance rates depends on ICD codes. During the transition to ICD-10 the quality contractor will need to assure that they are using only either ICD-9 data or ICD-10 data when calculating performance rates. Improper calculation of a hospital's performance rates would result in inaccurate quality data being posted on Hospital Compare. The impact is ***modest***.

- The claims processing systems will need to be modified to accept, load, adjudicated and store claims using the ICD-10 format. There are an extensive number of systems and processes that would need to be modified to process claims containing ICD-10 codes. The impact is ***high***.

10. The quality contractor will also analyze the hospital chart based quality measures performance rates from the Clinical Data Warehouse for inclusion in the Hospital Compare website. This process includes determining the performance rate for each indicator for those conditions monitored. For example one of the indicators for acute myocardial infarction is aspirin given upon arrival to the hospital. The performance rate for this indicator indicates what percentage of patients for a particular hospital received the aspirin on arrival

    Impact:

    - The process to calculate performance rates will need to be updated to accommodate the use of ICD-10 codes in the process. The actual performance rates do not contain ICD codes but the information needed to determine the data eligible for calculation of the performance rate depends on ICD codes. During the transition to ICD-10 the quality contractor will need to assure they are using only either ICD-9 data or ICD-10 data when calculating performance rates. Additionally, there will need to be consideration given to the reporting time lag of hospital quality data to the Clinical Data Warehouse during the transition. Improper calculation of a hospital's performance rates would result in inaccurate quality data being posted on Hospital Compare. The impact is ***modest.***

11. The quality contractor will then validate both the claims based measures and chart based measures performance rates.

    Impact: ***No Impact.***

12. The quality contractor then forwards hospital performance statistics to the Hospital Compare website contractor. CMS/OBIS provides oversight to the Hospital Compare website.

    Impact: ***No Impact.***

HOP QDRP (Hospital Outpatient Quality Data Reporting) Payment Initiative

1. The HOP QDRP process is a new initiative, driven by legislation, within CMS. It follows the same process as RHQDAPU with four exceptions. The four differences are:

    - Hospital outpatient measurement data is stored in the OPPS Clinical Data Warehouse instead of the Clinical Data Warehouse.

    - During the first year of HOP QDRP there is no validation of received data. If a hospital submits quality data that hospital will receive their APU. The process of validating received quality data will be incorporated into the process in 2009.

    - Data from the HOP QDRP process is not published to the Hospital Compare website. However, there are plans to include quality data collected from the HOP QDRP process by 2010.

    - The name of the Specification Manual for HOP QDRP is Specification Manual for Hospital Outpatient Department Quality Measures. The quality contractor, under the oversight of OCSQ/QMHAG/DHMM, has responsibility for publishing the Specification Manual.

    Impact:

    The overall impact to the HOP QDRP process is ***high*** due to the following:

    - The OPPS Clinical Data Warehouse will need to be modified to increase the field length size of the code fields and have the capability of accepting and storing both ICD-9 and ICD-10 codes,

    - The Specification Manual will need to be updated to include ICD-10 codes,

- The process of determining if a hospital has satisfactorily reported their quality data and is eligible for their full APU will need to be updated to accommodate the use of ICD-10 codes, and,

- The process of calculating performance rates will need to be updated to accommodate the use of ICD-10 codes.

The detailed information regarding these impacts can be found in the section above for the RHQDAPU process.

Process Risk Assessment

The quality measure and payment program initiatives processes will be impacted as a result of the transition to ICD-10. The specifications and algorithms for the numerous quality measures are dependent upon ICD-9 codes and all measures will need to be reviewed and updated with ICD-10 codes. Due to the increased granularity of ICD-10 mapping of particular codes from ICD-9 to ICD-10 is not always possible. In addition, the mapping is often a one-to-many relationship. The various mapping challenges could result in hospitals reporting inaccurate quality measure results. The hospital inpatient and outpatient measures are published in the Specification Manual which is a critical source of reference for hospitals. The manual provides the process steps, coding requirements and quality measures criteria necessary for quality measures reporting. The risk is ***high***[28].

The methodology used to calculate PQRI, RHQDAPU and HOP QDRP compliance rates for satisfactory reporting of measurement data will need to be updated with ICD-10 codes. If the measures and systems utilized to determine satisfactory reporting are inaccurately updated with ICD-10 codes, there is a risk providers will not be accurately identified as eligible for their incentive resulting in a loss of revenue for the provider. Additionally, there is a risk of providing inaccurate hospital quality data to publically accessible websites such as Hospital Compare. The Hospital Compare website is supplied with quality data collected and analyzed using ICD codes. If the transition from ICD-9 to ICD-10 is not conducted accurately, quality of care information available to consumers may be inaccurate. Additionally, there is the potential for hospitals to lose revenue due to the publication of inaccurate quality data. The risk is ***high***.

[28] A High or Red Level Process has the potential for significant cost (and/or schedule) increases to the project

Develop and Utilize Assessment Tools Impact Rank: High

Table 20. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Development and Utilization of Assessment Tools: **High**[29]	Center for Medicaid and State Operations (CMSO)/ Survey and Certification Group (SCG): Minor[30]	Center for Medicaid and State Operations (CMSO)/ Finance, Systems and Budget Group (FSBG) / Division of National Systems (DNS): High	Office of Clinical Standards and Quality Office of Clinical Standards and Quality (OCSQ) / Quality Measurement and Health Assessment Group (QMHAG) / Division of Post Acute & Chronic Care (DPACC): High	Center for Medicare Management (CMM) / Chronic Care Policy Group (CCPG): High
(Red Level)	(Green Level)	(Red Level)	(Red Level)	(Red Level)

Process Overview

A front-end policy analysis must be conducted before Medicare FFS payment systems can accurately pay based on ICD-10 codes. This analysis will be conducted as part of CMS' ongoing ICD-10 implementation planning process.

There are three processes associated with the Development and Utilization of Assessment Tools, which address analytical work; rule making; and operational changes to the various pricers, groupers, assessment instruments and claims processing systems. These processes include:

- Develop and Utilize Assessment Tools,
- Develop and Utilize Assessment Tools – Claims Submission, and,
- Develop and Utilize Assessment Tools – Home Health and Skilled Nursing Facility Reporting.

The Develop and Utilize Assessment Tools process highlights the development, collection, and reporting of assessment instruments data. The Division of Post Acute & Chronic Care (DPACC) within the Quality Measurement and Health Assessment Group (QMHAG) of the Office of Clinical Standards and Quality (OCSQ) is the business owner of the Minimum Data Set (MDS) for skilled nursing facilities and Outcome and Assessment Information Set (OASIS) for home health agencies. The Chronic Care Policy Group (CCPG) of the Center for Medicare Management (CMM) is the business owner of the Swing-Bed-Minimum Data

[29] Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.
[30] Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.

Set (SB-MDS) for swing bed hospitals and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) for inpatient rehabilitation facilities. The Division of National Systems (DNS) within the Finance, Systems and Budget Group (FSBG) of the Center for Medicaid and State Operations (CMSO) is responsible for the development of the software packages that providers can use to collect and report their assessment data. The data assessment software packages are: Resident Assessment Validation and Entry System (RAVEN) for skilled nursing facilities, Home Assessment Validation and Entry System (HAVEN) for home health agencies, Resident Assessment Validation and Entry System-Swing Bed (RAVEN-SB) for swing bed hospitals and Inpatient Rehabilitation Validation and Entry System (IRVEN) for inpatient rehabilitation facilities.

Skilled nursing facilities and home health agencies submit their assessment data to the respective federal server which is usually located in the State Survey Agency. Once received the data goes through validation edits and is then replicated to the National Quality Improvement and Evaluation System (QIES) reporting database. The data is viewed and state specific options are managed in either the OASIS or MDS data management system at the State. These State data management systems are maintained by CMSO/FSBG/DNS. Swing bed hospitals and inpatient rehabilitation facilities submit their assessment data to the National Assessment Collection system where the data goes through validation edits and is then replicated. The data is stored in the National Assessment Collection system and replicated to the National QIES reporting database. The National Assessment Collection system is managed by the QIES integration contractor. All four provider types, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and swing bed units use the Medicare Data Communication Network (MDCN) network to transmit the assessment from the provider to the collection server. The MDCN is maintained by CMSO/FSBG/DNS. QIES uses the data in the National Assessment reporting database for reporting and monitoring purposes. CMSO/FSBG/DNS is the business owner and system maintainer of the QIES systems. The assessment instruments data is used to conduct research, monitor patient care, and calculate payment rates.

The Develop and Utilize Assessment Tools - Claims Submission process identifies how grouper codes and Health Insurance Prospective Payment System (HIPPS) codes are calculated for each of the four provider types. The HIPPS code is a required data element on the providers' claims and is used to calculate reimbursement. The assessment instrument data play a crucial role in the determination of the correct grouper and HIPPS codes. The Provider Billing Group (PBG) of the Center of Medicare Management (CMM) provides specifications for updating and maintaining the case mix groupers to CMSO/FSBG/DNS. CMSO/FSBG/DNS is responsible for incorporating the grouper specifications into the data assessment software packages.

The Develop and Utilize Assessment Tools - Home Health and SNF process outlines how assessment instrument data from Home Health Agencies and Skilled Nursing Facilities are utilized in the calculation of quality measurement data for those providers. Quality measurement data from this process is used to update the Home Health Compare and

Skilled Nursing Facility Compare websites. These websites provide information to the public regarding the quality of care provided at a particular facility allowing the consumer to make a more informed decision about their health care. Additionally, the quality measurement data is used by state survey agencies to survey and certify home health agencies and skilled nursing facilities.

OCSQ/QMHAG/DPACC is currently in the process of developing updates to two of the existing assessment instruments, OASIS and MDS 2.0. OASIS C is a revision to the current OASIS assessment instrument and is scheduled for implementation in January of 2010. MDS 3.0 will be implemented in October of 2009 and is scheduled to run in parallel with MDS 2.0 for an undetermined period of time. Additionally, the flow of MDS 3.0 data from the provider to the Centers for Medicare & Medicaid Services (CMS) will be modified from the current flow of MDS 2.0 data as stated above. For MDS 3.0 the skilled nursing facility assessment data will be submitted to CMS and then back to the State Survey Agency.

The Continuity Assessment Record & Evaluation (CARE) instrument was recently developed as a result of the Congressional mandate for a Post Acute Care Payment Demonstration program. During this three year demonstration, the CARE instrument will be piloted. The anticipated outcome of the pilot should be a standardized patient assessment instrument that can be used across all post acute care providers. Post acute care providers who participate in the demonstration will continue to complete their existing assessment instruments (MDS, OASIS, etc) and information filtered from their current systems will provide data to the web based CARE data collection system. A final report on the demonstration is due to Congress in 2011. If the outcome findings result in the decision to implement CARE, then depending on the timing of this implementation there may be impacts to this assessment instrument that will need to be considered with the transition to ICD-10.

The two primary impacts of the ICD-10 implementation on these processes are the revisions to the assessment instruments and the reformatting and reprogramming of the various systems that collect store and report assessment instrument data. OCSQ/QMHAG/DPACC will have oversight of the assessment instruments contractors responsible for performing these updates. The various systems that collect, store and report assessment instrument data will require reformatting and reprogramming to accommodate ICD-10 codes. CMSO/FSBG/DNS will be required to make updates to RAVEN, HAVEN, RAVEN-SB and IRVEN to store expanded ICD-10 codes and incorporate new groupers specifications. CMSO/FSBG/DNS will be responsible for making updates to QIES, the state MDS and OASIS collection systems and the National Assessment collection system to store and manage expanded ICD-10 codes. CMSO/FSBG/DNS will be responsible for making updates to all QIES calculations, extracts and reports using the ICD-10 codes.

Related Processes

The Develop and Utilize Assessment Tools - Claims Submission process is interrelated to the Institutional Claims (Part A, Part B) process. The output of the Development and Utilize Assessment Tools - Claims Submission process is the creation of provider claims which are submitted for claims processing.

The Develop and Utilize Assessment Tools process is interrelated to the Collect and Deliver Chronic Condition Data process. The QIES generates outputs of MDS, OASIS, SB-MDS and IRF-PAI assessments data and sends it to the Chronic Condition Data Warehouse.

Process Description

Develop Quality Software and Assessment Instruments

1. OCSQ/QMHAG/DPACC and CMM/CCPG are the business owners of the assessment instruments. OCSQ/QMHAG/DPACC leads a collaborative workgroup to develop the requirements for the Minimum Data Set (MDS) and the Outcome and Assessment Information Set (OASIS). CMM/CCPG leads another collaborative workgroup to develop the requirements for the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) and the Swing-Bed Minimum Dataset (SB-MDS). The requirements for the assessment instruments rely on inputs from various sources such as studies and recommendations from the industry, federal mandates, quality measurement and quality improvement, survey and certification, and clinical relevance. Upon completion, the final requirements are gathered within OCSQ/QMHAG/DPACC and are forwarded to the assessment instrument contractor.

Impact: ***No Impact.***

2. The assessment instrument contractor, based on the requirements provided from OCSQ/QMHAG/DPACC, will develop and test the assessment instruments. The two areas to be tested and validated are the questions contained in the assessment instruments and the assessment application itself. OCSQ/QMHAG/DPACC oversees the testing of the reliability and validity of the questions contained in the assessment instruments. The application and the information technology that collects and stores the assessment instrument data is overseen by CMSO/FSBG/DNS.

Impact:

- The assessment instrument contractors, under the oversight of OCSQ/QMHAG/DPACC will be responsible for updating the assessment instruments with the transition to ICD-10. The assessment instruments collect

ICD codes and disease conditions information which is utilized to determine the clinical care a resident will receive. For example, the assessment instrument for skilled nursing facilities contains two components, the MDS and the Resident Assessment Protocol (RAP). The data items collected with the MDS is a core set of screening, clinical and functional status items of a resident. The clinical items collected with the MDS contain ICD codes and disease conditions that are pertinent to the resident. This clinical information collected with the MDS triggers the RAP. The triggered RAP then identifies social, medical or psychological problems and forms the basis for individualized care planning for the resident. The increased specificity of ICD-10 will require the 18 RAPs be reviewed and updated to accommodate ICD-10. In-depth ICD-10 education and training will be required for the assessment instruments contractors to ensure their full comprehension and ability to interpret ICD-10 code impacts on the RAPs. This impact is ***high***.

3. Upon completion of the development and testing of the assessment instruments, the assessment instrument contractor will provide the assessment instrument to OCSQ/QMHAG/DPACC for final approval.

Impact: ***No Impact.***

4. Once approved, the assessment instrument is forwarded to CMSO/FSBG/DNS who will incorporate the assessment instrument into the data assessment software packages (Microsoft Access application). These software packages allow for front-end data entry of the assessment instrument data by the various providers. ICD codes are one of the data fields within the software. The following information links the assessment instrument and data assessment software package to the corresponding provider:

    - Home Health Agency (HHA) utilizes the HAVEN software to collect OASIS data,
    - Skilled Nursing Facility (SNF) utilizes the RAVEN software to collect MDS data,
    - Swing Bed Hospital (SBH) utilizes the RAVEN-SB software to collect SB-MDS data, and,
    - Inpatient Rehabilitation Facility (IRF) utilizes IRVEN software to collect IRF-PAI data.

Impact:

- CMSO/FSBG/DNS will be responsible for updating the various data assessment software packages to accommodate the collection of ICD-10 codes. The current data fields for ICD-9 codes will need to be reprogrammed to accept the expanded field length of the ICD-10 codes and capture and store alphanumeric

codes. CMSO/FSBG/DNS will require basic knowledge regarding the differences in the structures of the ICD-10 code in order to accurately update the data assessment software packages. This impact is ***medium***[31].

5. The Provider Billing Group (PBG) of the Center of Medicare Management (CMM) provides specifications for updating and maintaining the case mix groupers to CMSO/FSBG/DNS. Once received CMSO/FSBG/DNS will incorporate into the respective data assessment software. The grouper is embedded within the data assessment software and allows the provider at a certain step during the entering of assessment data to enact or call the grouper. The following information links the data assessment software to the appropriate grouper:

    - HAVEN – Home Health Resource Groups (HHRG),
    - RAVEN – Resource Utilization Group (RUG),
    - RAVEN-SB – Resource Utilization Group (RUG), and,
    - IRVEN – Case Mix Group (CMG).

Impact:

- The specifications for building and creating the groupers logic and their algorithms rely on ICD-9 codes. PBG/CMM will be responsible for providing the specifications for updating and maintaining the case mix groupers to accommodate ICD-10 codes. CMSO/FSBG/DNS will be responsible for incorporating the case mix groupers specifications into the data assessment software. The output of the groupers is used to determine the payment that the provider will receive under the various prospective payment systems. Additionally, CMS analyzes claims data and assessment data to adjust payment rates. The contractors who create the grouper algorithms will require in-depth ICD-10 training in order to understand how ICD-10 maps to the current ICD-9 codes contained within the algorithms. Future considerations for grouper modification are made possible due to the increased specificity of ICD-10 allowing for enhanced payment rates. This impact is ***high***.

6. The finalized data assessment software packages are published to a CMS website where the software and specifications are made available for the providers to download. It was noted that the majority of providers use other third party vendor software to collect and report their assessment instrument data. Approximately two to five percent of skilled nursing facilities utilize RAVEN, approximately forty percent of home health agencies utilize HAVEN and almost all of inpatient rehabilitation facilities utilize IRVEN.

[31] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

Impact: ***No Impact.***

Collect Quality Assessment Data

The following processes represent the collection of assessment data for both HHAs and SNFs.

7. HHAs using HAVEN collect OASIS assessment data and SNFs using RAVEN collect MDS assessment data.

Impact:

- The information collected with assessment instruments is collected throughout the resident's encounter and not just at a point in time. During the transition to ICD-10 there will be instances where a resident's encounter begins on a date when ICD-9 is the required coding system and carries out through the date of the ICD-10 transition resulting in the collection of both coding classification systems during the encounter. A decision determining which coding system to capture on the assessment tools in this instance will need to be made. The impact is ***minor***.

8. The OASIS assessment data from the HHAs and the MDS assessment data from the SNFs are forwarded to the federal server usually located at the State Survey Agencies.

Impact: ***No Impact.***

9. Upon receipt of the assessment data, the federal server usually located at the State Survey Agencies will validate the data elements to ensure they comply with the specifications. For example, there must be a date field, date submission, and the dates need to be within a certain range for the data to be considered valid. If errors are found in the data, the federal collection system on the federal server usually located at the State Survey Agency can either reject the data or issue a warning to the provider. ICD codes are not one of the data elements edited but certain ICD codes for sexually transmitted diseases and HIV are discarded for those states that are not permitted to collect this sensitive information. The federal collection system on the federal server usually located at the State Survey Agency will use either an OASIS or MDS data management system to store and manage the assessment data. CMSO/FSBG/DNS is the system maintainer of the OASIS and MDS data collection and data management systems.

Impact:

- The OASIS and MDS submission systems will require updating with the transition to ICD -10. There may be a need for these systems to be able to accept and store both coding classification systems for a period of time. The logic in the two data management systems will require mapping of ICD-9 codes for sexually transmitted diseases and HIV to the respective codes in ICD-10 in order to continue to discard these codes for those states not permitted to collect this information. The data fields for the codes will not require expansion of the field length and the ability to accept and store alphanumeric codes. CMSO/FSBG/DNS will be responsible for overseeing the updating of these databases. The impact is ***minor***.

10. The assessment data is then replicated to the National QIES reporting database using replication procedures.

Impact: ***No Impact.***

The following processes represent the collection of assessment data for both SBHs and IRFs.

11. SBHs using RAVEN-SB collect SB-MDS assessment data and IRFs using IRVEN collect IRF-PAI assessment data.

Impact:

- IRFs are federally mandated to be in compliance with the "75% rule" which is one of the criteria used to determine if the facility may be classified as an IRF. IRF compliance criteria are based on the impairment groups and ICD-9 codes listed on the IRF-PAI assessment instrument. The ICD-9 codes listed on the IRF-PAI assessment instrument must meet at least one of the required medical conditions. An IRF could potentially lose its status as a qualified IRF if the current ICD-9 codes listed in the medical conditions list are not accurately mapped to ICD-10 codes. The impact is ***high***.

- The information collected with assessment instruments is collected throughout the resident's encounter and not just at a point in time. During the transition to ICD-10 there will be instances where a resident's encounter begins on a date when ICD-9 is the required coding system and carries out through the date of the ICD-10 transition resulting in the collection of both coding classification systems during the encounter. A decision determining which coding system to capture on the assessment tools in this instance will need to be made. The impact is ***minor***.

12. The SB-MDS assessment data from the SBHs and the IRF-PAI assessment data from the IRFs are replicated to the National QIES reporting database.

Impact: ***No Impact.***

13. Upon receipt of the assessment data, the QIES contractor, using the National Assessment Collection system, will validate the data elements to ensure they comply with the specifications. For example, there must be a date field, date submission, and the dates need to be within a certain range for the data to be considered valid. ICD codes are not one of the data elements edited but certain ICD codes for sexually transmitted diseases and HIV are discarded for those states that are not permitted to collect this sensitive information. Upon completion of the edits the QIES contractor will forward reports generated from this process back to the providers.

Impact:

- The QIES contractor under the oversight of CMSO/FSBG/DNS will be required to update the National Assessment Collection system with the transition to ICD-10. There may be a need for these systems to be able to accept and store both coding classification systems for a period of time. The logic within the National Assessment Collection system will require mapping of ICD-9 codes for sexually transmitted diseases and HIV to the respective codes in ICD-10 in order to continue to discard these codes for those states not permitted to collect this information. The data fields for the codes will not require expansion of the field length and the ability to accept and store alphanumeric codes. The impact is ***minor***.

14. The assessment data is then replicated to the National QIES reporting database using replication procedures.

Impact: ***No Impact.***

Report Quality Assessments

15. The National QIES reporting database receives the replicated data from the OASIS and MDS submission processes to the federal servers and the National Assessment Collection system. The QIES national reporting system, which is housed on Quality Net, uses the replicated data.

Impact:

- CMSO/FSBG/DNS will be required to update the QIES national reporting systems with the transition to ICD-10. There may also be a need for QIES and its repositories to accept and store both coding classification systems for a period of time. The QIES system provides the data for the reporting and analysis performed on the assessment data. The current data fields for ICD-9 codes will

not need to be reprogrammed to accept the expanded field length of the ICD-10 codes and capture and store alphanumeric codes. CMSO/FSBG/DNS will require basic knowledge regarding the differences in the structure of the ICD-10 codes in order to accurately update the QIES system and its data repositories. The impact is ***medium***.

16. Once the assessment data is captured in QIES, the QIES CASPER reporting tool will generate reports pulling data from the National QIES reporting data repositories housed within QIES. This includes the National QIES reporting databases 01 and 02.

Impact:

- The reports generated by the CASPER system do not contain ICD codes. However, the data used to create the reports does rely on ICD codes. The assessment reports are created based on the data received from the contractors. If the assessment instruments fail to accurately incorporate the changes based on the transition to ICD-10 then the assessment reports will either not be available or will be inaccurate. These reports are used by outside researchers, components within CMS (including CMM, ORDI and OCSQ), providers, and the state Medicaid offices. The impact is ***modest***[32].

Develop and Utilize Assessment Tools – Claims Submission

The following represents the claims submission process for HHAs, SNFs, SBHs, and IRFs

1. The provider will enter patient encounter data, including ICD-9 codes, into their claims software. If the provider does not have claims software the patient encounter data is collected manually.

Impact: ***No Impact.***

2. Utilizing the appropriate data assessment software package and grouper, the assessment instrument data elements are run through the grouper to generate a Health Insurance Prospective Payment System Code (HIPPS) code and grouper code. The HIPPS code is then electronically or manually submitted to the claims software. The following information outlines the assessment instrument, data assessment software and grouper used by each provider:

    - HHA – Utilize HAVEN software with HHRG grouper to collect OASIS data,

[32] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

- SNF – Utilize RAVEN software with RUG grouper to collect MDS data,
- SBH – Utilize RAVEN-SB software with RUG grouper to collect SB-MDS data, and,
- IRH – Utilize IRVEN with CMG grouper to collect IRF-PAI data.

Impact:

- The provider will be required to obtain updated data assessment software that includes the grouper with updated algorithms to accommodate ICD-10 within an appropriate time frame. It was noted that the majority of the providers do not use CMS supplied data assessment software. CMSO/FSBG/DNS will be responsible for modifying the data assessment software and grouper specifications as a result of the implementation of ICD-10. The impact to CMSO/FSBG/DNS is ***medium***.

3. Once the claim has been updated to include the HIPPS code, the provider will forwarded the finalized claim to the Fiscal Intermediary Shared System (FISS) for claims processing.

Impact: ***No Impact.***

Develop and Utilize Assessment Tools – Home Health and SNF

1. CMSO/FSBG/DNS provides oversight for generation of the HHA and SNF quarterly quality reports. Two set of reports are generated: provider level reports containing provider level measures and public reporting reports containing a subset of the provider level measures. The HHA quality reports (Outcome-Based Quality Improvement /Outcome-Based Quality Management (OBQI/OBQM)) are generated from OASIS data. SNF quality reports (Quality Improvement/Quality Measure (QI/QM)) are generated from data from MDS. CMSO/SCG bears responsibility for the QI reports and OCSQ/QMHAG is responsible for QM reports. The QM reports are risk adjusted and are used for public reporting of provider comparisons. Both the OASIS and MDS quality reports are produced by the QIES system from the data on the National QIES reporting database. HHA quality reports use ICD codes to develop a report outlining the top 10 diagnosis by category for a provider. SNF quality reports use ICD codes to identify the percentage of patients, per SNF, with certain conditions.

Impact:

- The quality reports for both the HHAs and the SNFs rely on data from the QIES system. The QIES system is fed from assessment data containing ICD codes. If the assessment instruments fail to transition from ICD-9 to ICD-10 correctly, the quality reports generated may be inaccurate or not available. The quality reports themselves do not contain ICD codes. The impact is ***minor***.

2. The OBQI/OBQM and QI/QM reports for public reporting are forwarded by CMSO/SCG to CMS/OBIS for publication in the Home Health Compare and Skilled Nursing Facility compare websites respectively. These reports do not contain ICD codes but the data used to generate these reports relies on ICD codes.

Impact: ***No Impact.***

3. State survey agencies, using the CASPER system, pull the quality OBQI/OBQM and QI/QM reports for their state. Data is provided at a provider level and with national totals. These reports do not contain ICD codes but the data used to generate these reports relies on ICD codes. Additionally, each HHA and SNF has access to their provider level reports through CASPER. The reports that the providers have access to contain their individual quality measures results, comparison of this quarter's results to previous results and their results compared to a national benchmark.

Impact: ***No Impact.***

4. The state survey agency initiates the survey and certification process for HHAs and SNFs.

Impact: ***No Impact.***

5. The state survey agency forwards the results of the survey and certification process to the HHAs and SNFs.

Impact: ***No Impact.***

Process Risk Assessment

The information collected within the data sets and assessment instruments is clinically driven by ICD-9 codes and is utilized to assess the level of care a patient requires. The data sets and assessment instruments are also used in the survey process to assess the quality of care provided by nursing homes, home health agencies, swing bed hospitals and inpatient rehabilitation facilities. The mapping between ICD-9 and ICD-10 is not a one-to-one match. Some ICD-10 codes will be expanded for what is currently a single ICD-9 code. In other instances, a single ICD-10 code may combine multiple ICD-9 codes. Mapping

between ICD-9 and ICD-10 can be "one-to-one", "one-to-many", many-to-one" or may not map at all. Inaccurate mapping of ICD-9 to ICD-10 could have an impact on the quality of care provided to patients. OCSQ/QMHAG/DPACC is in the process of developing MDS 3.0 which is targeted to be implemented on October 1, 2009. MDS 3.0 will run in parallel with the existing MDS 2.0 for an unidentified period of time. Based on implementation of ICD-10, there may be the need to modify and maintain both MDS 2.0 and MDS 3.0. OCSQ/QMHAG and CMSO/FSBG/DNS will have responsibility for updating the assessment instruments and data assessment software with the transition to ICD-10. The risk to this process is ***high***[33].

The accurate calculation of reimbursement for nursing homes, home health agencies, swing bed hospitals and inpatient rehabilitation facilities is dependent upon the ICD-9 codes embedded within the assessment instruments and their respective grouper. Inaccurate reimbursement or a delay in reimbursement could result if the systems are not updated correctly or mapping is incorrect. CMSO/FSBG/DNS bears responsibility for updating the data assessment software packages and incorporating the updated groupers specification into the software. The risk to this process is ***high***.

The accuracy of determining an inpatient rehabilitation facility's compliance with the "75% Rule" is dependent upon the impairment groups and ICD-9 codes collected on the IRF-PAI assessment instruments. In order to maintain IRF status and receive IRF reimbursement, the facility must be in compliance with the federally mandated criteria. IRF regulations require that at least 75% of the total patient population for the IRF must contain at least one medical condition (ICD code) that meets the required list of medical conditions outlined in the regulations. An IRF could potentially lose its status if 75% of their total inpatient population does not have at least one of the required medical conditions. IRFs are also required to submit their IRF-PAI assessment within 20 days of patient discharge or risk being assessed a 25% reduction in their payment from CMS. The risk to this process is ***high***.

Lastly, a potential risk exists to CMSO/SCG for providing training to approximately 128 MDS Coordinators. It is anticipated that the transition to ICD-10 may result in the need to provide training to MDS coordinators. The training provided would outline those modifications made to the MDS assessment instruments as a result of ICD-10 implementation. In addition training may be required for OASIS Education Coordinators and OASIS Automation Coordinators as a result of modifications made to the OASIS assessment instrument. The group responsible for providing this training was not identified. This risk to this process is ***minor***[34].

[33] A High or Red Level Process has the potential for significant cost (and/or schedule) increases to the project
[34] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project

Risk Adjustment Process Impact Rank: High

Table 21. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for **Process Rank: HIGH**[35]	Center for Drug and Health Plan Choice (CPC)/ Medicare Plan Payment Group (MPPG)/ Division of Risk Adjustment and Payment Policy (DRAP)	Center for Drug and Health Plan Choice (CPC)/MPPG/ DPV	Center for Beneficiary Choices (CBC)/ Medicare Drug Benefit Group (MDBG): Minor[36]	Center for Beneficiary Choices (CBC) / Medicare Advantage Group (MAG)	Center for Beneficiary Choices (CBC)/Plan Oversight & Accountability Group (POAG)
(Red Level)	(Red Level)	(Red Level)	(Green Level)	(Green Level)	(Green Level)

Process Overview

Medicare risk-adjusts the premiums it pays to health plans under the Medicare Advantage program and the Program for the All Inclusive Care of the Elderly (PACE). Risk adjustment is intended to ensure that on average payments or premiums are accurate for beneficiaries at any given level of expected cost (i.e. risk). This provides MA organizations with the appropriate incentives to enroll and retain beneficiaries regardless of their illness burden. Risk adjustment also helps provide MA organizations with protection against the risk of adverse selection. At the same time, risk adjustment lowers payments for beneficiaries expected to use fewer resources. The Centers for Medicare & Medicaid Services (CMS) uses risk adjustment data (captured through FFS claims and data submitted directly by MA plans) to group patients into risk adjustment categories and assign payments based on a member's medical condition group and create "risk scores." Under Medicare Part C, risk scores are used to standardize plan bids for bid comparison based on beneficiary populations with different health status and other characteristics.

Risk Score

The Medicare Plan Payment Group (MPPG) is responsible for bidding and payment policy for the Medicare Advantage (MA) and Prescription Drug plans. MPPG is comprised of six divisions. The Divisions primarily impacted by a transition to ICD-10 in the Risk Adjustment

[35] A High or Red Level Process will have an impact that, if the impact occurs, will cause significant cost (and/or schedule) increases to the project.
[36] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.

Process are the Division of Payment Validation (DPV) and the Division of Risk Adjustment and Payment Policy (DRAP).

The Risk Adjustment Process involves a number of system applications and databases, many of which use and store ICD-9 codes. The Front End Risk Adjustment System (FERAS) is used to capture clinical encounter data from managed care plans (Plans). Palmetto GBA, LLC is the current Medicare supporting contractor for risk adjustment data collection. Palmetto sends data to CMS from FERAS. The data from FERAS is edited and stored in the Risk Adjustment Processing System (RAPS), which is supported by IBM. RAPS edits, stores and reports data, including ICD-9 codes. RAPS produces reports for CMS, Palmetto and managed care plans. Reports to managed care plans are distributed through FERAS. The Risk Adjustment System (RAS) is the main application utilized for model runs. RAS is supported by IBM and the CMS Office of Information Systems (OIS) is the system maintainer.

CMS capitated payments for Part C and the direct subsidy component of Part D payment are based on beneficiary level risk scores and RAS is responsible for calculating these risk scores by executing model runs. RAS calculates risk scores, which include ICD-9 codes, for all Medicare beneficiaries – fee-for-service (FFS) and managed care. In order to compile all of the information to complete model runs, RAS performs data extracts from the Common Medicare Environment (CME), Medicare Beneficiary Database (MBD), and National Medicare Utilization Database (NMUD). RAS provides risk scores to the MARx payment system upon completion of each model run.

A reporting application within RAS, the risk adjustment analysis and reporting tool (RASART), also collects data from the Medicare Advantage Prescription Drug System (MARx) and Plan contract data from the Health Plan Management System (HPMS). Model run data is stored in the Risk monitoring database (RASART). RASART captures aggregated model run data and reports on plan submission and risk score metrics compared to benchmarks. MPPG performs analysis and reporting through an application from an external vendor, MicroStrategy.

CMS periodically recalibrated the risk adjustment models used for Part C and Part D payment. The Medicare contractor supporting model creation and recalibration (Research Triangle Institute/RTI) uses the Data Extraction System (DESY) to request and receive files. OIS is the business and system owner of DESY.

Overall, a transition to ICD-10 will have a ***high*** impact to the systems involved in the Risk Adjustment Process. Each system and interface must be evaluated to determine the readiness to support a transition to ICD-10. This includes systems internal and external to CMS. CMS and Medicare support contractors will need to target areas such as field character length in databases, formulas, calculations, reports and application user displays. Policies will also need to be updated in compliance with the regulation. Further, impact was identified for the Risk

Adjustment Data Validation (RADV) Process involving three contractors, systems and training needs.

Related Processes

Risk adjustment processes are dependent on accurate information supplied by other areas of CMS. The model run process relies on data from sources outside of MPPG.

1. RAPS collects data from FERAS, which is maintained by a Medicare contractor, Palmetto. FERAS data includes ICD-9 codes from Plans.

2. The Medicare Beneficiary Database (MBD) stores beneficiary records for Parts A, B, C and D enrollment, including eligibility for benefits, Medicaid enrollment and low-income subsidy benefits. The Division of Enrollment & Eligibility Policy (DEEP) of the Medicare Enrollment & Appeals Group (MEAG) is the system owner of MBD. RAPS also uses data from the "MDM Diagnosis Table," which stores ICD-9 codes.

3. RAS uses FFS claim data, including ICD-9 codes from NMUD. NMUD fee-for-service data comes from the Common Working File (CWF) and the National Claim History (NCH). The Office of Information Services' Enterprise Database Group (OIS/EDG) is the system owner of NMUD.

4. RAS uses beneficiary institutional status from the Minimum Data Set (MDS). MDS is data used to support the assessment of long-term-care residents.

5. RAS uses prescription drug plan enrollment data from the Medicare Advantage Prescription Drug System (MARx). MARx processes enrollment and disenrollment transactions related to the Medicare Part D prescription drug benefit. It also recalculates Plan payments due to Part D risk adjustment factor reconciliations. The Medicare Plan Payment Group (MPPG) is the business owner of MARx.

6. RAS also uses Plan contract data from the Health Plan Management System (HPMS). HPMS is owned and maintained by the Plan Oversight & Accountability Group (POAG).

Impact:

The transition to ICD-10 by sources external to MPPG will have a ***high*** impact on risk adjustment processes. The RAPS and RAS systems will need to be evaluated and updated to accommodate ICD-10 codes from the various systems providing data to the risk adjustment activities. Data from external sources will need to be tested before being used for risk adjustment activities.

MPPG supplies information to other areas of CMS and external entities.

1. RAS produces Risk Adjustment Processing System (RAPS) return files which are critical for Plan review of their data submissions.
2. RAS produces Model Output Reports which are critical for Plan review of payment accuracy.
3. RAS produces risk adjustment scores for all Medicare beneficiaries which are loaded into MARx for payment adjustments to all Part C and D enrollees.
4. MPPG provides detailed risk adjustment data to the Office of the Actuary (OACT) and the Office of Research, Development, and Information (ORDI).
5. RAS produces research files for authorized users.

Impact:

A transition to ICD-10 will have a ***high*** impact to the activities receiving data from the risk adjustment process. In particular, the information used by MARx must be correct to ensure accurate payments are issued to plans. FERAS and RAS will need to be evaluated and updated to accommodate ICD-10 codes. Before changes are accepted, time will need to be scheduled to test the impact of changes made to systems, extract processes and data exchanges. CMS will need to work with the FERAS support contractor, Palmetto, to ensure data acceptability, data exchanges and reporting are in working order. MPPG will need to plan for additional costs associated with system changes.

Process Description

Implement Risk Adjustment Payment Policy Process

1. Legislation and CMS initiatives drive policy for risk adjustment.
2. Upon receipt of new initiatives, MPPG creates policy to manage the changes.
3. Non-routine changes, such as the transition to ICD-10, are published through the *Annual Notice* of changes to payment methodology and subject to public comment.
4. After changes are accepted, the new model is created.
5. MPPG develops system requirements to meet the needs of legislation and new initiatives.
6. MPPG communicates system changes to Medicare support contractors to update systems such as the Risk Adjustment Processing System (RAPS) and the Risk Adjustment System (RAS).
7. The Medicare support contractors develop, test and implement changes to the systems as requested by MPPG.

Impact:

With the assumption ICD-10 will be mandated, a transition to ICD-10 will have a ***high*** impact to the Implement Risk Adjustment Payment Policy Process. MPPG will need to prepare for a mandate to transition to ICD-10. New initiatives may also come from the transition to ICD-10. MPPG may want to investigate what new initiatives may be scheduled for the future, post-implementation of ICD-10.

Calibrate Model - Create Algorithms Process

CMS uses risk adjustment data (captured through claims data) to create risk scores and group patients into risk adjustment categories associated with a beneficiary's medical condition group. The process of generating risk scores is referred to as a "model run." In order to complete a model run, a series of algorithms must be in place in the Risk Adjustment System (RAS). The algorithms are created by an analytic Medicare support contractor (RTI) and then made available to the RAS support contractor (IBM) to be applied to future model runs in RAS. Algorithms are utilized in new models as well as recalibrating existing models. Currently CMS manages risk adjustment in 3 key payment ("model") areas: (1) Part C - CMS-Hierarchical Condition Category (HCC), (2) Part C - End Stage Renal Disease (ESRD) and (3) Part D prescription drug (RxHCC). The End Stage Renal Disease (ESRD) model is calculated based on three separate models of defined stages for ESRD: Dialysis, Transplant (first 3 months prior to transplant) and Post-transplant (three months following transplant).

Part C/CMS-HCC

1. The Create Model – Run Algorithms Process begins with creating new models or scheduled model recalibrations for existing models. Recalibration is currently scheduled for one time every two years to help keep up with changing expenditure patterns.
2. The analytics support contractor (RTI) is notified by MPPG with the model requirements.
3. To create or recalibrate a model, the Medicare support contractor pulls a five percent sample of non-physician claims data using data from the CMS Standard Analytic Files, which are a subset of data from the National Claims History (NCH). The Standard Analytic Files are not used for physician claims. Instead, the Medicare supporting contractor pulls five percent of actual claims. The Medicare supporting contractor uses the Data Extraction System (DESY) to request and receive files.
    a. For the ESRD models, the process is the same except the Medicare support contractor (RTI) pulls claim data specific to beneficiaries designated as ESRD-entitled. The support contractor uses a 100% data sample due to the small size of the population. Before the model is created, additional analysis is performed by MPPG to ensure the correct files are selected.
    b. Once a year, the Office of Information Services (OIS) makes a new set of Standard Analytical Files available.

4. The Medicare support contractor combines all data (including ICD-9 codes) into one dataset and builds a file of predictors, demographic factors and disease diagnoses. Diagnosis codes are grouped in Hierarchical Condition Categories (HCCs).
5. The Medicare support contractor runs a regression model for model variables and disease categories. The regression model returns coefficients with associated predicted costs. Coefficients are expressed in dollar terms. Therefore, every unit of HCC has an associated cost and the HHC costs are directly tied to ICD-9 codes, which were used to create the HCC groups. Every ICD-9 diagnosis code is used and links to an HCC. The Medicare support contractor also builds a demographic model used to predict utilization costs for new beneficiaries for which there are no claim data.
6. The new algorithms are made available to the RAS support contractor (IBM). IBM updates RAS and new model data is used to obtain an average predicted cost for everyone under the model.

Impact:

A transition to ICD-10 will have a ***high*** impact to the Calibrate Model - Create Algorithms Process for Part C. MPPG and the Medicare support contractor (RTI) will need to work together to ensure there is a way to map existing ICD-9 codes to new ICD-10 codes. This is not a one-to-one map. Algorithms may need to be analyzed and rewritten to accommodate the analytics supporting model generation and recalibration. MPPG and the support contractor will need time to evaluate, implement and test new algorithms. Both MPPG and the support contractor will also need a full understanding of the ICD-10 changes and the implications of using both sets of codes (this may involve additional training for various users.) MPPG may need to plan for additional contractor costs associated with implementing ICD-10 changes.

Part D/RxHCC - Calibrate New Model Algorithms

The current Part D model was developed assuming an unlimited drug benefit, and was then adjusted for the plan's liability under the Medicare standard Part D benefit. The Part D risk adjustment model shares most of the characteristics of the CMS-HCC model. That is, the model is prospective, additive, hierarchical, and contains demographics on new enrollees. The key differences are:

- The Part D model is designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than Medicare Part A/B costs.
- Different diseases predict drug costs rather than Part A/B costs.
- Incremental costs of low-income (LI) and long-term institutional (LTI) beneficiaries are multipliers to the base RxHCC model score.

Like the CMS-HCC model, the Part D model uses the presence of particular demographic characteristics and diagnoses to predict costs in the following year for an individual. The model clusters a set of ICD-9 diagnoses within groups that are similar clinically and in terms of their expected costs. The groupings used to predict drug spending are variants of the groups

used to predict Part A and B spending, and the data sources for diagnoses are the same as those used in Part C. As in the CMS-HCC model, some of the disease groups fall into hierarchies. Hierarchies are imposed in order that the highest cost category of the related diseases is triggered and the lower cost category does not increase the Part D risk score.

1. To calibrate, the MPPG pulls Part A, B and D claims data for two years. The data is obtained from the Medicare Standard Analytic Files, including ICD-9 codes from physician, hospital outpatient, and hospital inpatient claims. From this data, CMS creates a beneficiary diagnosis input file. This information is provided by MPPG to the Medicare analytics support contractor (RTI). Demographic information for the risk scores is obtained from MBD/CME.
2. The Medicare support contractor combines all data (including ICD-9 codes) into one dataset and builds a file of predictors, demographic factors and disease diagnoses. Diagnosis codes are grouped in Hierarchical Condition Categories (RxHCCs).
3. The support contractor (RTI) runs a regression model for model variables and disease categories. The regression model returns coefficients with associated predicted costs. Coefficients are expressed in dollar terms. Therefore, every unit of RxHCC has associated costs and the RxHHC costs are directly tied to ICD-9 codes used to create the RxHCC groups. The Medicare support contractor also builds a demographic model used to predict utilization costs for new beneficiaries for which there is no claim data.
4. New algorithms are made available to the RAS support contractor (IBM). IBM updates RAS and new model data is used to obtain an average predicted cost for everyone under the model.

Model changes are published each year in *Advanced Notice of Methodological Changes for Calendar Year (CYXXX) for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies for public comment and finalized in the Announcement of Calendar Year (CYXXX) Medicare Advantage Capitation Rate and Medicare Advantage and Part D Payment Policies.*

Impact:

A transition to ICD-10 will have a ***high*** impact to the Calibrate Model - Create Algorithms Process for Part D. MPPG and the Medicare support contractor (RTI) will need to work together to ensure there is a way to map existing ICD-9 codes to new ICD-10 codes. This is not a one-to-one map. Algorithms may need to be analyzed and rewritten to accommodate the analytics supporting model generation and recalibration. MPPG and the support contractor will need time to evaluate, implement and test new algorithms. Both MPPG and the support contractor will also need a full understanding of the ICD-10 changes and the implications of using both sets of codes (this may involve additional training for various users.) MPPG may need to plan for additional contractor costs associated with implementing ICD-10 changes.

Collect Data Process

1. The Collect Data Process begins when a provider submits Medicare beneficiary encounter data (including ICD-9 data) to the beneficiary's Medicare managed care plan (also known

as a Medicare Advantage Plan or MA Plan). Prescription data is submitted to the Medicare Advantage Prescription Drug contractor (MA-PD).

2. The MA/MA-PD Plan compiles the health status data and reports it to the Risk Adjustment Front End System (FERAS) contractor responsible for transmitting Medicare risk adjustment data to CMS.
3. The FERAS system edits Plan data for acceptability.
    a. Data is checked for file-level acceptability, batch-level acceptability and first/last detail field validity.
4. If there is a problem with the data, the contractor returns a data error report (FERAS Response Report) to the Plan. The Plan may then correct and resubmit the data to Palmetto through FERAS.
5. If the data is correct, the supporting contractor sends the data to CMS for further analysis and reporting.

Impact:

A transition to ICD-10 will have a ***high*** impact to the Collect Data Process. Prior to implementation, MPPG will need to work with the Medicare supporting contractor to identify FERAS application processes, database tables and ICD-9 fields requiring modification to accommodate the change to ICD-10.

Submit Data Process

1. After passing the FERAS checks, the file is submitted to the CMS Risk Adjustment Processing System (RAPS).
2. Upon receipt of the approved FERAS data, CMS uses RAPS to validate the data before it is fully accepted.
    a. RAPS performs detailed editing or data validation.
    b. RAPS returns a number of data reports which document the status of each risk adjustment transaction. RAPS generates reports such as the Return File Report, Transaction Error Report, Transaction Summary Report, Duplicate Diagnosis Cluster Report (contains ICD-9), Cumulative Plan Activity Report and the Error Frequency Report.
3. Valid Plan data is stored in the RAPS Database.
    a. The RAPS Database is a DB2 database.
    b. The database stores risk adjustment data submitted by Plans.
3. Valid ICD-9 codes are stored in RAPS.
4. RAPS return files are distributed through FERAS to the Plans. The Plan may correct and resubmit erroneous data through FERAS.

5. The Medicare support contractor (IBM) also assists MPPG with developing and interpreting statistical reports for trends in Plan performance and beneficiary care. Their analysis uses ICD-9 codes.
    a. The supporting contractor manages the risk-monitoring database (RASART), which is a central repository for risk adjustment data.
    b. RASART houses data from a variety of sources such as: Cumulative Transaction Reports from FERAS and RAPS, Monthly and Quarterly Membership by Contract provided from the CMS Model Output Summary Reports, and Pre-Model Diagnosis Detail Data (Diagnosis, date-of-service, beneficiary level detail) and Plan Activity Reports. ICD-9 codes are included in the stored data.

Impact:

A transition to ICD-10 will have a ***high*** impact to the Submit Data Process. Prior to implementation, MPPG will need to work with the supporting contractor (IBM) to identify RAPS application processes, database tables and ICD-9 fields requiring modification.

Calculate Risk Scores Process – Parts C and D

1. When fully accepted, the data from RAPS is compiled in the Risk Adjustment System (RAS) to calculate risk adjustment factors to be applied to a Plan's capitation (payment) rate.

2. RAS calculates Risk Adjustment Factors (risk scores) by executing the applicable model runs. RAS calculates risk scores, which include ICD-9 codes, for all Medicare beneficiaries – FFS and managed care. RAS also loads risk scores for payment application and is managed by a Medicare supporting contractor (IBM).

3. To create input data for model runs, RAS runs data extracts:
    a. Extracts beneficiary enrollment and eligibility data from the CME (Common Medicare Environment - maintains Medicare Beneficiary Eligibility Data). CME data does not include ICD-9 codes.
    b. Extracts plan reported beneficiary diagnoses (ICD-9 codes) from RAPS and utilizes a table (MDM Table) from the Medicare Beneficiary Database (MBD), which also stores ICD-9 codes.
    c. Extracts beneficiary FFS provider reported diagnoses (ICD-9 codes) from NMUD. NMUD provides FFS data by way of the Common Working File (CWF) and the National Claim History (NCH). This process also utilizes the MDM table.
    d. Collects beneficiary institutional status based on the Minimum Data Set (MDS) data.

4. After the data extracts have been generated, RAS associates the diagnosis codes with the correct beneficiaries. Since a beneficiary may be referenced using more than one unique key in the NMUD and RAPS databases, a "link key" is attached to the beneficiary in MBD and is used to uniquely identify beneficiaries and their associated diagnosis codes. The link key sync process makes the correct association between diagnosis codes and a beneficiary.

5. RAS divides the beneficiaries from the data extract into three different cohort groupings: FFS, managed care and ESRD for purposes of running risk score calculations.

6. For each payment year, risk adjustment data is included in three separate "model runs." A fourth run is performed to create the rate book for future years.

    a. Each model run accounts for changes to beneficiary enrollment statuses and diagnosis data (ICD-9 code data) from Plans and Medicare FFS providers.

    b. The Model Run schedule is as follows:

        i) Initial Model Run – This is typically performed in the fourth quarter of the previous year to determine initial risk adjustment scores for the following year.

        ii) Mid-year Model Run –This run is performed 3 months into the current year. The mid-year payment model run is used to update the risk adjustment scores created during the initial payment model run using data that is more current. The payment system uses these risk adjustment scores to adjust payments for those beneficiaries whose scores have changed since the initial model run.

        iii) Final Model Run –This run is performed approximately in July–August following the payment year. This run is to create the final (and most accurate) risk adjustment score for the previous year because, unlike the previous runs, it is able to utilize a longer run-out period for risk adjustment data to finalize beneficiaries eligibility and enrollment status.

        iv) Budget neutrality and rate book run—this run is used to create the rate book for future years and to make sure the rate changes result in total program payments are budget neutral. This run is made in the beginning of the year prior to the payment year.

7. The Risk Adjustment Factor (RAF) and Model Output Report (MOR) data is loaded into MARx for Part C and D payment application. ICD-9 codes are not included. MARx identifies individuals enrolled in an organization for a particular month. Then it accesses the risk factor file to retrieve the appropriate risk factor for each individual. MARx uses the individual's state and county code to determine the correct county capitation rate and then multiplies the risk factor by that rate. After calculating the correct demographic payment for the same individual, MARx then calculates the correct payment by blending the appropriate proportion of risk and demographic payments. Then the demographic and risk adjusted amounts are totaled.

8. Following entry to MARx, payment data are available for the Automated Plan Payment System (APPS) and the Financial Accounting System (FACS) business activities. AAPS and FACS activities do not involve ICD-9 codes.

9. Model Output Reports (MOR) and Monthly Membership Reports (MMR) are made available to the MA Plans.

    a. The MOR displays the HCCs used by RAS to calculate risk adjustment factors for each beneficiary. The report displays the HCC Disease Groups used by the CMS-HCC

model and disease and demographic interactions. The Part C Risk Adjustment MOR provides detailed information on the specific disease groups and disease interactions triggered for an enrollee. Disease hierarchies are not identified separately. If a hierarchy exists, only the most severe manifestation in the hierarchy is displayed on the report.

b. The MMR provides information to Plans for reconciling Medicare membership and payment records compared to the records maintained by CMS. The MMR is available in two formats – report and data file, which are posted monthly. The report and data file formats provide summary and detail-level information about beneficiaries belonging to a Plan. The MMR does not contain ICD-9 codes.

10. In RAS, and following each run, enrollment data from the Medicare Advantage Prescription Drug System (MARx) and Plan contract data from the Health Plan Management System (HPMS) is added to the Model Run data.

11. Following the model runs, MPPG places research files on the CMS mainframe at the CMS Data Center and provides authorized users access to the risk scores. The data is in the form of a file with information from the Model Output Reports (MOR) and the Risk Adjustment Factor File (RAF). There are no ICD-9 codes in the research file. It resides on the development side of the CMS mainframe.

12. Risk Adjustment data is also housed in the RASART reporting environment

    a. RASART is a database. It uses ETL (Extract, Transform and Load) processes.

    b. RASRT contains RAPS data, model run data from RAS, beneficiary enrollment data from MARx and Plan contract data from HPMS.

    c. RASART provides risk adjustment reports for MPPG.

    d. RASART reports submission patterns.

13. The combined data is also utilized to create Risk Adjustment Factor (RAF) and Model Output Reports (MOR) reports. MPPG also utilizes a software application by MicroStrategy for additional data mining. MicroStrategy references a few tables in RASART, which are known to need changes to accommodate the transition to ICD-10. The specific RASART tables have not been named.

Impact:

A transition to ICD-10 will have a ***high*** impact to the Calculate Risk Score Process. First, MPPG will need to work with support contractors to identify RAS processes, database tables and ICD fields will need to be modified. New ICD-10 codes do not have a one-to-one relationship with the current ICD-9 codes. Therefore, the Risk Adjustment Models will require recalibration to accommodate the new code relationships. MPPG is currently conducting research to identify the best method(s) for mapping historical ICD-9 code data to new ICD-10 code data. The group is considering cross-walking large blocks of codes. The proposed crosswalk would map ICD-9 codes into ICD-10 codes and would require additional training for end-users. Finally, MPPG will also need to work with supporting contractors to identify system and reporting modifications. Although diagnosis codes are not actually moved into RASART, a few database tables will be impacted by the transition to ICD-10. MicroStrategy uses a few RASART tables that will be impacted. Specific tables have not been identified.

Risk Adjustment Data Validation Process (RADV)

The Risk Adjustment Validation Process has been updated from the previous Medical Record Review Process. The purpose of Risk Adjustment Validation is to ensure payment integrity and accuracy. The objectives are to confirm discrepancies associated with payments, measure payment errors and identify problematic MA contracts (RAVD does not apply to Part D services.) The Risk Adjustment Validation Process is an annual process of validating medical records to ensure a MA Plan's risk adjustment diagnosis (ICD-9 code) submitted for payment is based on clinical medical record documentation from a face-to-face patient/provider encounter, coded according to the *ICD-9-CM Official Guidelines for Coding and Reporting,* assigned based on dates of service within the respective data collection period and submitted to the MA Plan from an appropriate risk adjustment provider type.

There are six stages of the RADV process:

Stage 1	Sampling and Medical Record Request
Stage 2	Medical Record Review (MRR) – initial and second validation reviews
Stage 3	MRR Findings and Contract-level Payment Adjustments
Stage 4	Documentation Dispute
Stage 5	Post Documentation Dispute Payment Adjustment
Stage 6	Appeals – CMS Office of Hearings

Sampling and Medical Record Request

1. The Division of Payment Validation (DPV) has an annual schedule for performing Payment Validation. Annually, the Medicare Technical Data Processing Support (TDPS) contractor (FU Associates) performs a data abstraction and develops a statistical sample of beneficiaries from which medical records are selected for medical record review. Sample selections are abstracted for beneficiary data in MARx and the HCCs in RAS.

2. Sample selections are sent from the TDPS to Medicare Lead Analytic Contractors (LACs) for analysis and action.
    a. LACs decide which sample cases will have a medical record review (MRR).
    b. LACs track the results of all medical record reviews.
    c. LACs determine what level of review is to be performed.
    d. The LAC performs data analysis to determine coders come to similar review conclusions.
    e. LACs are using their own Statistical Analysis System (SAS), which is in the process of being approved by OIS. The application has not been named.
3. The LACs then distribute samples to Medical Record Review Contractors (MRRCs) for first-level reviews. The MRRC conducting the first-level MRR is referred to as the MRRC1.
    a. MRRCs do not use CMS systems, but use abstraction tools internal to the MRRCs.
    b. MRRCs track, request and review medical records.
    c. MRRCs report MRR findings to the LACs.
4. The MRRC1 receives the sample list from the LAC and requests the medical records from a beneficiary's contracted Plan.
5. The Plan returns medical records to the MRRC1 within a specified amount of time.

Medical Record Review (MRR) – Initial and Second Validation Reviews

1. The MRRC1 receives the record and conducts a first-level MRR. The results of the review are returned to the LAC.
2. The LAC determines whether a record is discrepant and sends the record to a second MRRC (MRRC2) for further review.
    a. As an integrity check, LACs also send a small subset of records (without discrepancies) to the MRRC2 for additional review.
    b. There are more than two levels of review. To date, the process is expected to have at least three levels with two levels of review being the norm.
3. The MRRC2 receives the record and conducts a second-level MRR.
4. The results of the review are returned to the LAC.

MRR Findings and Contract-level Payment Adjustments

1. The LAC analyzes the MRR data in terms of ICD-9 codes to determine incorrect or correct Plan payment.

2. The model is run in order to calculate the correction and the payment adjustment is calculated in MARx. After MARx, the adjustment is sent to APPS and the adjusted payment is performed.
3. The Plan receives the adjustment.

Document Dispute Process (To-be process)

The Document Dispute process is in the process is being formalized. These activities have yet to be implemented.

1. The Plan will contact the MRRC2 with documentation to support their dispute. There may be some negotiation between CMS, the MRRC and Plan to decide which ICD-9 codes should be used.
   a. If the findings are not in favor of the Plan, the Plan may appeal. See next step, *Appeals – CMS Office of Hearings*
2. All findings will be communicated by the MRRC to the Plan and the LAC.

Post Documentation Dispute Payment Adjustment (To-be process)

The process for Post Document Dispute Payment Adjustments is being formalized. These activities have yet to be implemented. A Documentation Dispute system has not been identified.

1. If dispute findings are in favor of the Plan, the LAC will generate another level of payment adjustment. Recalculating the plan payment is more complicated than correcting a FFS claim. Multiple diagnoses may need to be run through the model in order to calculate a new payment for a Plan beneficiary.
2. The documentation dispute process will have a defined start/finish for the plans. MRRCs will be required to submit Document Dispute findings to the LAC.
3. The LAC estimates a correct Plan payment figure and then runs it through the payment/model. The payment adjustment is calculated in MARx. The adjustment is sent to APPS and the adjusted payment is performed.
4. The Plan receives the adjustment.

Appeals – CMS Office of Hearings

The process for Appeals is being formalized. These activities are not final. An appeal system has not been identified.

1. The plan may appeal the findings from the Document Dispute step by contacting the MRRC2 to initiate the appeal.
2. The MRRC2 will forward the case to a Payment Adjustment and Appeal Contractor (PAAC).

3. The PAAC will compile all information related to the MRR and dispute. The PAAC will then forward the case information to the CMS Office of Hearings.
4. The CMS Office of Hearings will make a determination for or against the Plan.
    a. The MRRC2 will notify the Plan with the case ruling.
    b. The LAC will adjust the payment.
5. The Plan receives the adjustment.

Impact:

A transition to ICD-10 may have a ***high*** impact to the Risk Adjustment Data Validation Process (RADV). Failure, anywhere from plan data submission to MPPG model run activities, could result in incorrect Plan payments, which will result in a significant increase in the number of medical records subject for review. MPPG will need to work with the LACs and MRRCs to ensure abstraction tools are capable of managing MRR activities. MPPG will need to consider additional contractor costs associated with supporting ICD-10 codes. Although further information is needed to complete the documentation of this process, the need for ICD-10 training was immediately identified. The support contractor medical record review staff will need to be trained to understand the differences between the two code sets in order to interpret diagnosis information included in the medical records.

Process Risk Assessment

Overall, the current method for completing risk adjustment must change with the transition to ICD-10. A transition to ICD-10 codes presents a ***high***[37] risk to each of the risk adjustment processes because the entire structure of risk adjustment is based on ICD-9 codes. Nearly every activity and system (RAS, RAPS, FERAS, MARx) may be considered ***high*** risk. With an incomplete transition to ICD-10, there is a potential for risk adjustment business processes and system functions to breakdown. A failure in the risk adjustment activities will cause some or all areas of risk adjustment to function inaccurately or perhaps halt completely. In the transition period, there is a possibility of payment interruption due to recalculated risk scores. MPPG is spending considerable time working to prevent this occurrence.

Without an accurate and tested map from the current ICD-9-based risk adjustment structure to the new ICD-10 risk adjustment structure, MPPG will be unable to produce accurate risk scores. In this case, MA and Part D plan payments will be at risk.

Of note, MPPG publications state the public has the right to comment on non-routine changes to risk adjustment model calculations. By statue, MPPG publishes proposed changes to payment methodology in the Advanced Notice rather than the *Federal Register*. It is possible a transition to ICD-10 will pose changes (or risk to plan payments) significant enough to warrant

[37] A High or Red Level Process will stop, work or payment will cease at time of transition

publication in the *Federal Register* and time for public review/comment before ICD-10 codes can implemented for the risk adjustment process.

Mapping

MPPG anticipates using data maps to crosswalk ICD-9 codes to ICD-10. The data mapping between ICD-9 and ICD-10 is not a one-to-one match. Some ICD-10 codes will be expanded (or offer more than one choice) for what is currently a single ICD-9 code. In other cases, a single ICD-10 code may combine multiple ICD-9 codes. This is a complex process. Mappings between ICD-9 to ICD-10 can be "one-to-one", "one-to-many," "many-to-one" or may not map at all. Implementation and interpretation of the maps will require personnel with a skilled knowledge of ICD-9 and ICD-10 and many hours will be required to interpret the data produced from such maps. Data comparability will also be affected because of the differences between the code systems. Maintenance of code maps will be necessary for longitudinal data analysis, as well as the ability to conduct trend analysis. When comparing information produced from both sets of coding systems, there is a potential risk for flawed decisions due to distorted or inaccurate interpretation of data due to the differences in the code definitions. The fact that MPPG does not deal with procedure codes, means no additional work is required aside from diagnosis codes for an ICD-10 implementation. Eventually due to increased specificity of the ICD-10 codes, it is hoped the model will be even more accurate for specified groups of beneficiaries.

Algorithms may need to be analyzed and rewritten to accommodate the analytics supporting model generation and recalibration. Not only will algorithms need to be analyzed and rewritten, MPPG will create risk scores with ICD-10. Models will need to be tested to ensure new algorithms calculate the models similarly (budget neutral) to when models were only created using ICD-9. If the model run results, after implementing ICD-10, are not similar to past model runs, Plan payments will be incorrect. Plans may object to the model results, and the process may have to stop until further analysis and model algorithm adjustments are made.

Currently DRAP is building new crosswalks and assessing the needs of additional crosswalks beyond the General Equivalence Mappings (GEM) files currently available for the two systems. DRAP is proactively conducting a clinical review of the models and regrouping all ICD-9s to have a new clinical approach to the future model when the transition to ICD-10 occurs. Then the crosswalk from the ICD-9 CCs must be built to map to relative ICD-10 CCs. In order to build a crosswalk for the CCs, DRAP must analyze comparative data to ensure the ICD-10 CCs match or are similar to current CCs for ICD-9.

Data Analysis/Trending

Challenges will be encountered in data analysis and risk score development. Adding a large number of new codes and rewriting models may present a risk to DRAP. This is a complex process. Data comparability may be less reliable and confusing during and after the transition. Diagnoses will be classified differently between the two coding systems. Therefore, caution is

required when interpreting longitudinal data. It is possible that for a period, productivity and accuracy may suffer until code interpretation is finalized. Until code interpretation is finalized, the following activities are at risk:

- Statistical reports for data analysis
- Historical data comparison
- Retrospective audits
- Model trend analysis

Timing

The payment period for the Risk Adjustment Process encompasses three calendar years. This presents certain risks to MPPG. Even though the logic of the model will not change because of ICD-10, DRAP has begun planning to communicate the impact/risks to all involved in the process. To mitigate risks, it is important to understand the Risk Adjustment Processes, and the needed changes affecting the processes.

An implementation date of 2011 has a two-fold ***high*** risk to the risk adjustment processes.

1. Collecting data in 2011 (which includes the ICD-10 codes.)
    a. Normally payment is based on a calendar year's worth of diagnosis data (Jan 1 – Dec. 31) for the following year. The risk to MPPG is the period of time in which data is collected based on 9 months of ICD-9 and 3 months of ICD-10.
2. Running of models.
    a. Later in 2013 when the models are run, the processes will actually be using a mix of codes.

MPPG has begun developing strategies to mitigate the risk. One option discussed is a change to some of CMS risk adjustment timelines that could result in the transition to ICD-10 having a longer glide path.

Training

Through 2008, Risk Adjustment Regional Training was made available to all Plans. There is no budget or staff allocated to continue such training for future years. Any new training provided to the Plans should explain changes related to ICD-10 and how those changes will impact Plan operations and payment. The lack of training during this transition period represents a **high** risk to MA-PD plans.

Systems

DRAP has identified four major areas affecting the Risk Adjustment Process posing risks:

- RAPS system - every file will change and is highly impacted; this transition period is a high risk to MA-PD plans.

- RAS system, which calculates the risk factor – high, risk, and will require tremendous testing.
- RASART - fairly new application with impact. Further investigation is suggested.
- Training – no budget, no staff

The above three systems constitute 90% of work and risk to systems during the transition to ICD-10.

The system field lengths must be expanded to accommodate expanded data element length to seven alphanumeric characters. During the transition, there is a ***high*** risk to CMS to fully and completely test the systems. MPPG identified concerns about the level of resources needed to run the current business operations and conduct testing. Further, CMS will also need the hardware and software to run parallel processes during the transition.

Risk Adjustment Data Validation (RADV)

Consistent with other components in the Risk Adjustment Process, the transition to ICD-10 presents a ***high*** level of risk to the Risk Adjustment Data Validation process. DPV works with several contractors (discussed above). Currently the MRRCs use their individual data abstraction tools. These contractors are responsible for edits to their tools, but CMS pays for those tools. At this time, it is not known how the contracts will be re-negotiated. The ability of all contractors to update their systems will be a risk to DPV. These updates need to be completed in time to prevent a negative impact to the RADV process. Failure to properly implement ICD-10 in any system or process between the LACs and MRRCs may cause slowdowns, stoppage or increased work for DPV.

Data analytics poses the largest risk to DPV. Everyone, including the Plans is familiar with the ICD-9 codes and where they currently map. The unknowns of ICD-10 pose a risk because adding or redefining many new codes necessitates redoing models. Using all of these codes translates to difficulties in analyzing the data, which makes the entire process even more difficult and complex than usual. Mapping the ICD-9 codes to ICD-10 does not translate to a "one-to-one" match because the systems are different. The ability to conduct trend analysis is at risk. In addition, the SAS application utilized for data analytics will need to be updated correctly.

The RADV process is dependent on abstracting information from RAS and MARx. There is a risk to the RADV processes caused by inefficiencies in ICD-10 changes to these systems. In addition, consideration is being given to a new data analytic tracking system for MPPG. This system would need to be able to accommodate the format of ICD-10 codes.

DPV conducts training for all contractors (LACs, MRRCs, TDPS) and it is anticipated ICD-10 training would be necessary. In addition, MRRCs do their own coding training (built into the contract). During contract re-negotiations, training needs must also be considered.

Further, through 2008, Risk Adjustment Regional Training has been provided to all Plans. However,, no contracts have been let to support such training. If such training were re-instated, the scope of developing training plans and conducting training will present a ***high*** risk to DPV.

Currently DPV has a coding module used in regional training, but it is anticipated Plans will have many questions about ICD-10 and what to expect. Currently training has been done with the MRRC coders assisting. It is not known if additional ICD-10 coding experts will be needed to provide this Regional training. DPV may consider paying for coders at the MRRC to receive comprehensive training on ICD-10 and then develop training materials and subsequently provide training. The training provided to the Plans would not be on how to code in ICD-10, but rather on how ICD-10 feeds the risk adjustment models. To minimize the risk, Plans will need training on why certain codes will be accepted for payment and others will not be. Communication on what ICD codes feed the models is vital to mitigate risk with the Plans. It is imperative that Plans understand the changes to the models and the changes to their payment. DPV plans to collaborate with DRAP on training the Plans.

Timing issues also present risk to DPV since the entire process revolves around a calendar year of payment (partial ICD-10 and partial ICD-9 codes in one payment year.) If the transition occurs October of 2011, the impact will be felt for 2012 payment (audited in 2013).

Another area of risk for DPV may be an increase in payment disputes from Plans. Since this is a new process, it is unknown how many appeals are currently conducted. However if the Plans do not understand the new payment system, or fail to understand how to crosswalk the codes to HCCs to calculate payment, Plans may not understand how payment is calculated, and may dispute the payment. It will be imperative for contractors to understand how to handle this increased number of codes, as the risk adjustment process will have much more complexity.

Other Users of Risk Adjustment Data

There is a risk to users of Risk Adjusted data. Specifically identified as having ***minor*** risks are the following Groups:

- **Medicare Drug Benefit Group (MDBG)**
  Currently, MDBG divisions do not utilize ICD-9 information nor does ICD-9 factor into their day-to-day activities. Therefore, MDBG has determined a transition to ICD-10 will present a ***minor***[38] risk to their group. Occasionally MDBG has performed data analysis on risk adjusted data (from MPPG), but this is not done routinely and is not part of their principal focus. In a transition to ICD-10, MDBG would work with MPPG to adapt crosswalks and interpret the missing gaps in data using recalibrated models. The risk to the group is thought to be ***minor***.

- **Medicare Advantage Group (MAG)**
  MAG does not work with ICD-9 codes directly, nor does MAG analyze data or make projections based upon risk-adjusted data. However, MAG uses calculated capitated rates provided by MPPG in contract planning. This data is in the form of aggregate data. MAG may have an indirect risk in the event MPPG is unable to effectively complete their risk adjustment process due to lack of historical ICD data and/or data

[38] A Minor or Green Level Process has the potential for minimal or routine modifications to the process

mapping between ICD-9 and ICD-10 codes. The risk to the group is thought to be ***minor***.

- **Plan Oversight & Accountability Group (POAG)**
  Currently, ICD-9 codes are not utilized by POAG divisions nor does ICD-9 information factor into their day-to-day activities. However, as a result of poor ICD-10 implementation, POAG may identify plans not in compliance with beneficiary service and claim processing requirements. When identified, these cases would be managed in the regular course of POAG business. Because POAG receives risk adjusted data from MPPG, POAG may have an indirect risk in the event MPPG is unable to effectively complete their risk adjustment process due to lack of historical ICD data and/or data mappings between ICD-9 and ICD-10 codes. Therefore, POAG has determined a transition to ICD-10 will present ***minor*** risk to their group.

Support Quality Improvement Activities and End-Stage Renal Disease (ESRD) Networks
Impact Rank: High

Table 22. Process Summary Report ICD-10 Implementation Impact Ranking

Process Rank for Quality Improvement Organizations (QIOs) program: High[39]	Office of Clinical Standards and Quality (OCSQ) / Information System Group (ISG) / Division of Quality Improvement Organization QIO Systems & Contract Management (DQSCM): High	Office of Clinical Standards and Quality (OCSQ) / Quality Improvement Group (QIG)/ Division of Quality Improvement Policy for Acute Care (DQIPAC) Modest[40]	Office of Clinical Standards and Quality (OCSQ) / Quality Improvement Group (QIG)/ Division of Quality Improvement Policy for Chronic & Ambulatory Care (DQIPCAC): Modest	Office of Clinical Standards and Quality (OCSQ) / Quality Measurement & Health Assessment Group (QMHAG)/ Division of Post Acute & Chronic Care (DPACC): Modest	Office of Clinical Standards and Quality (OCSQ) / Information System Group (ISG) / Division of End-Stage Renal Disease (ESRD) Systems & Contract Management (DESCM): Minor[41]
(Red Level)	(Red Level)	(Yellow Level)	(Yellow Level)	(Yellow Level)	(Green Level)

Process Overview

Quality Improvement Organizations (QIOs)

The Quality Improvement Organizations (QIOs) program is a key component of the Centers for Medicare & Medicaid Center's (CMS) broad agenda to improve the care for Medicare beneficiaries. QIOs are private, mostly not-for-profit, organizations staffed by physicians, nurses and other healthcare professionals. CMS contracts with one organization in each state as well as the District of Columbia, Puerto Rico and the U.S. Virgin Islands to serve as the state's or jurisdiction's QIO.

The statutory mission of the QIO program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. CMS identified the core functions of the QIO program as:

- Improving quality of care for beneficiaries
- Protecting the integrity of the Medicare Trust fund by ensuring that Medicare pays only for services that are reasonable and necessary and that are provided in the most appropriate setting
- Protecting beneficiaries by expeditiously addressing individual complaints such as beneficiary complaints and provider-based notice appeals

[39] A High or Red Level Process has the potential for significant cost (and/or schedule) increases to the project.
[40] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.
[41] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

CMS awards three year QIO contracts falling under successively numbered Statements of Work (SOW). Currently, the 9th SOW, running from August 1, 2008 to July 31, 2011, focuses on improving the quality and safety of healthcare services to Medicare beneficiaries. The 9th SOW has six main themes or processes. Three themes are national topics and are required of all fifty-three QIO contractors. The remaining three themes are sub-national and are optional for the QIOs. The six themes of the 9th SOW are:

- Beneficiary protection (national)
- Patient safety (national)
- Core Prevention (national)
- Care Transitions (sub-national)
- Prevention Disparities (sub-national)
- Prevention: Chronic Kidney Disease (sub-national)

Beneficiary Protection Theme

The Division of Quality Improvement Policy for Acute Care (DQIPAC) within the Quality Improvement Group (QIG) of the Office of Clinical Standards and Quality (OCSQ) is responsible for the development of the Beneficiary Protection theme within the 9th SOW

The Beneficiary Protection theme requires QIOs to perform statutorily mandated review activities including:

- Reviewing the quality of care provided to beneficiaries
- Responding to beneficiary complaints
- Reviewing higher weighted Medicare Severity-Diagnosis Related Groups (MS-DRGs) requests from hospitals.
- Supporting hospitals with submission of Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) quality data

Patient Safety Theme

OCSQ/QIG/DQIPAC is responsible for the development of the Patient Safety theme of the 9th SOW.

The Patient Safety theme requires QIOs to focus on the following activities:

- Reducing health care associated Methicillin-resistant Staphylococcus aureus (MRSA) infections
- Reducing rates of pressure ulcers in hospitals and nursing homes
- Reducing rates of physical restraint usage in nursing homes
- Improving inpatient surgical safety and heart failure treatment in hospitals
- Improving drug safety; and
- Providing quality improvement technical assistance to Nursing Homes in Need (NHIN)

Core Prevention Theme

The Division of Quality Improvement Policy for Chronic & Ambulatory Care (DQIPCAC) within OCSQ/QIG is responsible for development of the Core Prevention theme within the 9th SOW.

QIOs will work with participating physician practices to implement effective interventions to improve rates among Medicare beneficiaries. The Core Prevention Theme identifies the following preventative measures that QIOs should focus on:

- Breast cancer screening
- Colorectal cancer screening
- Influenza vaccinations
- Pneumonia vaccinations.

Care Transitions sub-national Theme

The Division of Post Acute & Chronic Care (DPACC) within the Quality Measurement & Health Assessment Group (QMHAG) of OCSQ is responsible for the development of the Care Transitions sub-national theme.

The Care Transitions sub-national theme requires the QIOs in fourteen states to coordinate care and promote seamless transitions across health care settings. This includes monitoring beneficiaries as they transition from hospitals to post-acute settings such as nursing homes and home health agencies. As a function of this theme, QIOs will work to reduce the number of beneficiaries re-admitted to a hospital from post-acute care facilities.

Prevention Disparities sub-national Theme

The DQIPCAC is responsible for the development of the Prevention Disparities sub-national theme within the 9th SOW.

For the Prevention Disparities sub-national theme, the QIOs will work in five states to support Diabetes Self-Management Education efforts. These efforts will focus on diabetes management and target underserved racial and ethnic populations.

Prevention Chronic Kidney Disease (CKD) sub-national Theme

DQIPCAC is responsible for the development of the Prevention: CKD sub-national theme in the 9th SOW. QIOs, working with ten states, will implement the Prevention CKD sub-national theme.

This theme focuses on:

- Slowing the progression of CKD to kidney failure
- Improving the clinical care for all patients with CKD.

Impacts

The QIOs rely on data supplied by CMS components to carry out their tasks as outlined in the 9th SOW. A primary impact, resulting from the transition from ICD-9 to ICD-10, will be on the systems used to supply data to the QIOs. The Division of Quality Improvement Organization (QIO) Systems and Contract Management (DQSCM) within the Information System Group (ISG) of OCSQ will be responsible for updating and reprogramming the following systems to accommodate ICD-10 codes:

- Administrative Warehouse
- Health Account Joint Information (HAJI) Part A and Part B
- Case Review Information System (CRIS)
- Care Transitions Database

Additionally, OCSQ/ISG/DQSCM will be responsible for rewriting the HAJI algorithms used to calculate the prevention and some of the patient safety measures. It is unclear how the analytic processes will handle measure periods that utilize both ICD-9 and ICD-10 codes. If coding schemes for both ICD-9 and ICD-10 are required a crosswalk would need to be used to account for changes in format, content and meaning. Analytic code used to fulfill CMS-approved Standard Data Processing System (SDPS) adhoc data requests will also need to be modified to allow for a combination of ICD-9 and ICD-10 coding schemes. The analytic files with the Care Transitional Database will also need to be rewritten to accommodate ICD-10 codes.

A second impact will be to the OCSQ divisions who jointly share the responsibility for the development of the QIO SOW and evaluation of the QIOs' performance. Under the SOW, QIOs' establish baseline rates at the beginning of the contract period and work to improve these baseline rates for each theme. The QIOs are ultimately evaluated on their ability to work with providers and demonstrate improvements to the baseline rates.

If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, a modification to the contract may be required. Additionally, the ability of OCSQ to assess the QIOs' performance may be affected if the measures have to be redefined as a result of the ICD-10 implementation.

End-Stage Renal Disease (ESRD) Networks

The End-Stage Renal Disease (ESRD) Network program is a legislatively mandated program consisting of a national network of eighteen ESRD Networks which service geographic areas based on number and concentration of ESRD beneficiaries. The program's responsibilities include:

- Assuring the effective and efficient administration of benefits
- Improving quality of care for ESRD patients
- Collecting data to measure quality of care

- Providing assistance to ESRD patients and providers
- Evaluating and resolving patient grievances

The ESRD SOW delineates the activities and tasks to be conducted by the ESRD Networks. The ESRD SOW requires the ESRD Networks develop a Network Quality Improvement Program. Two of the tasks required under the Network Quality Improvement Program are:

- Participation in the Vascular Access (Fistula First) Quality Improvement Project
- Collection and analysis of data on the ESRD Clinical Performance Measures (CPMs).

The Fistula First project involves the use of ICD-9 codes and requires the ESRD Networks to collect aggregate vascular access data for dialysis facilities using the Fistula First data collection tools. The ESRD Networks are to collaborate with the QIOs on the Fistula First project as outlined in the QIOs 9th SOW. The CPMs do not contain ICD-9 codes, but ICD-9 codes are used to pull the relevant claims for the CPMs. The results of three of the CPMs are posted on Dialysis Compare.

Currently, approximately 400 of the 4,000 dialysis facilities use Vital Information System to Improve Outcomes in Nephrology (VISION) software to electronically submit the 2728 form. The remaining facilities manually complete the 2728 form and send the paper form to their respective ESRD Network. The 2728 form is then entered into the Standard Information Management System (SIMS). The 2728 form and VISION contain a pre-determined list of ICD-9 diagnoses utilized to identify the primary cause of the patient's kidney failure. OCSQ/QIG/DQIPCAC will be responsible for updating the current ICD-9 codes on the 2728 form with ICD-10 codes. Once updated, OCSQ/QIG/DPIPCAC will be required to take the updated 2728 form through the OMB approval process. The VISION software does not contain a table of ICD-9 codes but allows for the data entry of the codes listed on the 2728 form.

The Consolidated Renal Operations in a Web-enabled Network (CROWNWeb) system is currently being developed and is scheduled for rollout in February, 2009. Over several years, CROWNWeb will replace the existing CROWN family of applications. The CROWN components to be replaced by CROWNWeb include: VISION, SIMS and Renal Management Information System (REMIS). CROWNWeb will be the data system used for mandatory electronic submission of the 2728 form for all Medicare certified dialysis facilities. Once CROWNWeb is fully operational REMIS and SIMS will no longer be utilized for the ESRD Network program. CROWN (REMIS, SIMS and VISION) contain a subset of ICD-9 codes. Depending on the timing of ICD-10 implementation versus timing of CROWNWeb being fully operations, the Division of ESRD Systems & Contract Management (DESCM) within OCSQ/ISG will be responsible for modifying CROWNWeb (and possibly REMIS and SIMS) to accept the limited number of ICD-10 codes used in CMS ESRD systems.

The ESRD Network Program processes were not diagrammed or discussed in detail in this report due to the limited involvement of their processes with ICD codes.

1. Multiple CMS mainframe programs identify inpatient claims data (including inpatient stays, transplants and other procedures) related to the identification of ESRD patients or their treatment. This data is used to establish ESRD coverage periods and also to assist the ESRD Network

Organizations in identifying and tracking ESRD patients. This CROWN functionality will continue in the new CROWNWeb application

Impact:

- CROWN and CROWNWeb will need to be updated to accommodate the change in field length from ICD-9 to ICD-10. OCSQ/ISG/DESCM will be responsible for the modifications with the transition to ICD-10. The impact is ***minor***.

Related Processes

The Beneficiary Protection theme of the Support Quality Improvement Activities and ESRD Networks process is interrelated to the Develop and Support Quality Measures and Payment Initiatives process.

Process Description

Implement Beneficiary Protection Theme

Determine Payment for Higher Weight DRGs

1. OCSQ/ISG/DQSCM receives a monthly TAP file of every inpatient claims from the National Claims History (NCH). This TAP file is loaded into the Administrative Warehouse.

Impact:

- The Administrative Warehouse and its programs must be updated to accommodate ICD-10 codes. Additionally, the Administrative Warehouse code will need to be modified to accept and store both ICD-9 and ICD-10 codes. The impact is ***medium***[42].

2. A program within the Administrative Warehouse identifies if a hospital has submitted two claims for the same patient with the same date of service and the MS-DRG for the second claim has a higher weight. Once identified, the program flags the claims. The QIOs are notified monthly of all claims that qualified for a higher weighted MS-DRG review. The QIOs using the Standard Data Processing System (SDPS) will retrieve the identified claims from the Administrative Warehouse for review.

Impact:

- Identification of higher weighted claims will require analysis of claims including ICD codes. With the transition to ICD-10, OCSQ/ISG/DQSCM will need to reprogram the algorithms within the Administrative Warehouse used to identify claims with higher weighted MS-DRGs. The impact is ***medium***

3. The QIOs will request the corresponding medical records from the providers.

Impact: ***No Impact***

[42] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

4. Upon receipt of the medical records, the QIO will determine if the medical record supports the ICD-9 diagnosis and/or procedure codes submitted on the higher weighted MS-DRG claim. Based on this assessment, the QIO has the authority to cancel payment on the higher weighted claim. A letter is sent to both the Medicare Administrative Contractor (MAC) and the hospital notifying them of the final MS-DRG and payment decision. Additionally, the QIO will update the Case Review Information System (CRIS). The CRIS system stores diagnosis and procedure codes. The QIO can enter diagnosis and procedure information and CRIS will call a grouper which will calculate the correct MS-DRG.

Impact:

- The CRIS system will need to be updated to accommodate the change in field length from ICD-9 to ICD-10. An updated grouper will also need to be purchased to be installed in CRIS. OCSQ/ISG/DQSCM will be responsible for the modifications to CRIS with the transition to ICD-10. The impact is ***modest***.
- With the transition to ICD-10, the QIOs will need to be able to review claims and medical records with ICD-10 codes. The QIOs will require in-depth ICD-10 training in order accurately continue the higher weighted MS-DRG process. The impact is ***modest***.

Investigate Beneficiary Complaints

1. Beneficiaries have the opportunity to file a written complaint regarding the quality of their care. The QIOs are responsible for the investigation of beneficiary complaints made through 1-800-Medicare or directly to a QIO.

Impact: ***No Impact***

2. The QIO will accept the beneficiary complaint for investigation.

Impact: ***No Impact***

3. The QIO will request the appropriate medical records from the provider.

Impact: ***No Impact***

The QIO will review the medical record for quality of care issues. Additionally, the QIO will obtain the corresponding claims from the Administrative Warehouse. The claim is not necessary in order for the QIO to perform the quality of care issues but is utilized as additional information if available. The QIO does not utilize diagnosis and procedure codes or the MS-DRG to conduct the review. The QIO will make a determination as to whether a quality of care concern was identified. A response is provided to the beneficiary. For significant (gross and flagrant) quality concerns the QIO would do a referral to the Office of the Inspector General (OIG) for sanction and the QIO would work with the OIG through the sanction process. Additionally, the QIO will update the CRIS with details regarding the investigation. The CRIS system stores diagnosis and procedure codes.

Impact:

- The CRIS system will need to be updated to accommodate the change in field length from ICD-9 to ICD-10. OCSQ/ISG/DQSCM will be responsible for the updates to CRIS. The impact is ***modest***.
- The Administrative Warehouse and its programs will need to be updated to accommodate ICD-10 codes. Additionally, since there is no time limit for the filing of a beneficiary complaint, the Administrative Warehouse will need to store claims with both ICD-9 and ICD-10 codes. The impact is ***medium***.

Support Patient Safety

1. The Patient Safety theme requires patient safety data to be collected and supplied to the QIOs. The following outlines the patient safety measures and their corresponding data source:

    - Pressure Ulcers – data sources are National Claims History (NCH) for hospitals and Quality Improvement Evaluation System Minimum Data Set (QIES MDS) for nursing homes
    - Physical Restraints – data source is QIES MDS
    - Surgical Care Improvement (SCIP)/Heart Failure – data source is Clinical Data Warehouse (CDW)
    - MRSA – data source is from the National Health Safety Network (NHSN) of the Centers for Disease Control (CDC) (does not contain ICD codes)
    - Drug Safety – data sources are HAJI Part A and Part B and Part D data file
    - Nursing Home in need – data source is Certification and Survey Provider Enhanced Reporting (CASPER) (does not contain ICD codes)

Impact:

- OCSQ/ISG/DQSCM will be responsible for the modifications to HAJI Part A and Part B and the Clinical Data Warehouse to accommodate the increased field length of ICD-10 codes. The warehouses will also need to accommodate the receipt and storage of both ICD-9 and ICD-10 codes. The impact is ***medium***.
- OCSQ/ISG/DQSCM will be responsible for rewriting the HAJI algorithms used to identify some of the patient safety measures. It is unclear how the analytic processes will handle measure periods that utilize both ICD-9 and ICD-10 codes. If coding schemes for both ICD-9 and ICD-10 are required a crosswalk would need to be used to account for changes in format, content and meaning. The impact is ***medium***.
- Although OCSQ/ISG/DQSCM will not be responsible for the modification of the other systems listed above, their ability to supply the QIOs with accurate data received as feeds from these systems could be affected if the systems are not transitioned to ICD-10 correctly or timely. The impact is ***modest***.

2. The QIOs will analyze the patient safety data to identify trends and develop strategies to improve beneficiary outcomes for these six measures.

Impact: ***No Impact***

3. The QIOs will provide OCSQ/QIG/DQIPAC with reports detailing the progress being made in meeting the objectives set forth in the Patient Safety theme. These reports will include:

- Status report on MRSA findings (submitted at 18 months and 28 months)
- Reports on disparities between nursing homes by states (submitted every 6 months)
- Reports regarding the amount of technical assistance provided and associated best practices related to prescription drug therapy (submitted every 6 months)
- Reports outlining quality improvement initiatives implemented for each of the patient safety themes (submitted quarterly)

Impact:

- OCSQ/QIG/DQIPAC will receive the QIO progress reports and is responsible for evaluating the performance of the QIO in respect to the Patient Safety theme. Under the SOW, QIOs establishes baseline rates and are subsequently evaluated regarding their ability to work with providers to improve the rates. If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, OCSQ/QIG/DQIPAC may be required to modify the contract. Additionally, the ability of OCSQ/QIG/DQIPAC to accurately assess the QIO's performance may be affected if the measures have to be redefined as a result of the implementation of ICD-10. The impact is ***modest***.

Monitor Core Prevention

1. OCSQ/ISG/DQSCM receives a monthly TAP file containing both Part A and Part B claims data from NCH. The TAP file is loaded into HAJI Part A and Part B. This data is used to identify claims for the Core Prevention theme measures as follows:

    - Mammography screening
    - Colorectal screening
    - Influenza immunizations
    - Pneumococcal immunizations

    Quarterly, OCSQ/ISG/DQSCM will run algorithms to extract core prevention measure from the claims data housed on HAJI. The measures data is then forwarded to the QIO. Analytic files based on the measure analysis are made available for the QIO request via the Standard Data Processing System (SDPS) adhoc request process.

Impact:

- OCSQ/ISG/DQSCM will be responsible for modifying HAJI Part A and Part B to accept and store the increased field length size of ICD-10 codes. Additionally, HAJI will need to be modified to accept both ICD-9 and ICD-10 codes. The impact is ***medium***.
- OCSQ/ISG/DQSCM will be responsible for rewriting the HAJI algorithms used to identify the core prevention measures. Each of the measures is identified by ICD-9 codes and since each measure has different ICD-9 codes each algorithm will need to be rewritten to accommodate the respective ICD-10 codes. The impact is ***medium***.

2. The QIOs will perform analysis on the prevention data collected. QIOs will identify trends and calculate rates for prevention activities. Based on their findings, the QIOs will develop strategies for providers and beneficiaries to understand the importance of disease prevention, early detection, and lifestyle modifications.

Impact:

- The data used by the QIOs to develop prevention strategies relies on ICD codes. ICD codes are used to identify those claims that contain any of the four core prevention measures outlined in the QIO's SOW. If the transition from ICD-9 to ICD-10 is not implemented accurately, the data supplied and stored in the HAJI database may not be accurate. If the QIOs relied on inaccurate claims data to identify prevention trends their ability to identify and implement targeted prevention activities will be negatively impacted. The impact is ***modest***.

3. OCSQ/QIG/DQIPCAC will receive periodic reports from the QIOs detailing the progress made on implementing the Core Preventive initiatives. Examples of QIO reports will include
    - Recruitment of Participating Practices (PPs) (submitted monthly)
    - Identification and recruitment of non-participating practices (NPs) (submitted by the end of the second quarter of the contract)
    - Eligibility of PPs and NPs to participate in the prevention program
    - Status reports on submission rates of prevention measures from PPs and NPs
    - Annual Report showing the baseline and rates for PPs and the statewide trends on each measure and disparities

Impact:

- OCSQ/QIG/DQIPCAC will receive the QIO progress reports and is responsible for evaluating the performance of the QIO in respect to the Core Prevention theme. Under the SOW, QIOs establishes baseline rates and are subsequently evaluated regarding their ability to work with providers to improve the rates. If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, OCSQ/QIG/DQIPCAC may be required to modify the contract. Additionally, the ability of OCSQ/QIG/DQIPCAC to accurately assess the QIO's performance may be affected if the measures have to be redefined as a result of the implementation of ICD-10. The impact is ***modest***.

Support Care Transitions

1. OCSQ/ISG/DQSCM receives a monthly TAP file containing both Part A and Part B claims data from NCH. The TAP file is loaded into HAJI Part A and Part B. This data will contain Part A claims originating from inpatient records, Skilled Nursing Facility records, Home Health Agency records and Long Term Care Hospital records.

Impact:

- The HAJI system will need to be updated to accept and store the increased field length size of ICD-10 codes. Additionally, HAJI will need to be modified to accept and store both ICD-9 and ICD-10 codes. The impact is ***medium***.

2. OCSQ/ISG/DQSCM using the data collected in HAJI will develop and populate the Care Transitions Database. The Care Transitions Database contains data used to calculate seven of the Care Transition measures (I1-I4, I6, O3 and O6). Data from the Care Transitions Database will be used to identify and monitor the care provided to beneficiaries who transition from an acute care hospital to a post-acute care setting.

Impact:

- The algorithms contained in the Care Transitions Database will need to be updated as a result of the transition from ICD-9 to ICD-10. The Care Transitions Database will need to be re-coded to identify those beneficiaries who fall under the Care Transitions program. The impact to this process step will be ***medium***.

3. Proportions of Transitions as well as the measures rates are stored in Care Transitions Database and utilized by the Patriot application. OCSQ/ISG/DQSCM will take information from the Care Transitions Database and place into reports for the QIOs.

Impact:

- The information stored in the Care Transitions Database is used to create QIO reports which utilize ICD codes. If the conversion from ICD-9 to ICD-10 is not implemented correctly, the QIO reports may be inaccurate. The impact is ***minor***.

4. Three additional Care Transitions measures will be calculated by a quality contractor under the oversight of OCSQ/QMHAG/DPACC. These three re-admission Care Transitions measures will be calculated utilizing claims data from a TAP file from NCH. Once calculated the readmission rates will be provided to the QIOs.

Impact:

- The process to calculate the readmission rates will need to be updated to accommodate the use of ICD-10 codes. The actual rates do not contain ICD codes but the information needed to determine the data eligible for calculation of the readmission rates depends on ICD codes. During the transition to ICD-10 the contractor will need to assure that are using only either ICD-9 data or ICD-10 data when calculating readmission rates. The impact is ***modest***

5. The QIOs will perform analysis of the Care Transition measurement data received from both the quality contractor and Care Transitions Database. QIOs will identify trends and calculate rates for Care Transitions activities. Based on their findings, the QIOs will develop strategies for reduction in readmission rates following hospitalization.

Impact:

- The data used by the QIOs to develop Care Transitions strategies relies on ICD codes. If the transition from ICD-9 to ICD-10 is not implemented accurately, the data supplied to the QIOs may not be accurate resulting in the QIOs being unable to accurately identify and implement targeted Care Transitions activities. The impact is ***modest***.

6. The QIOs will provide OCSQ/QMHAG/DPACC with reports detailing the progress being made in meeting the objectives set forth in the Care Transitions theme. These reports will include:
    - Identification of geographic area and the associated health care delivery system that will participate in the CARE Transitions theme (delivered one month after contract award)
    - Strategic plan for organization, intervention, monitoring, and decision-making for the CARE Transitions theme
    - Description of the impact that the QIO efforts have had on the observed patterns of inappropriate or wasteful services affecting re-hospitalization rates. Delivered at 18, 28, and 34 months following contract award)

Impact:

- OCSQ/QMHAG/DPACC will receive the QIO progress reports and is responsible for evaluating the performance of the QIO in respect to the Care Transitions theme. Under the SOW, QIOs establishes baseline rates and are subsequently evaluated regarding their ability to work with providers to improve the rates. If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, OCSQ/QMHAG/DPACC may be required to modify the contract. Additionally, the ability of OCSQ/QMHAG/DPACC to accurately assess the QIO's performance may be affected if the measures have to be redefined as a result of the implementation of ICD-10. The impact is ***modest***

Monitor Prevention Disparities

1. OCSQ/ISG/DQSCM receives a monthly TAP file containing Part A and Part B data from NCH. The TAP file is loaded into HAJI Part A and Part B. The Part B data originating from physician encounters will be used to identify and monitor beneficiaries who meet the identified criteria for the Prevention Disparities theme. The Prevention Disparities theme focuses on monitoring underserved and minority populations who have diabetes.

Impact:

- OCSQ/ISG/DQSCM will be responsible for modifying HAJI Part A and Part B to accept and store the increased field length size of ICD-10 codes. Additionally, HAJI will need to be modified to accept both ICD-9 and ICD-10 codes. The impact is ***medium***.

2. OCSQ/ISG/DQSCM will run algorithms to extract measurement data for the prevention disparities measures from the Part B claims data house in HAJI.

Impact:

- OCSQ/ISG/DQSCM will be responsible for rewriting the HAJI algorithms used to identify the measurement data for the prevention disparities theme. Each of the measures is identified by ICD-9 codes and will need to be rewritten to accommodate the respective ICD-10 codes. It is unclear how the analytic processes will handle measure periods that utilize both ICD-9 and ICD-10 codes. If coding schemes for both ICD-9 and ICD-10 are required a crosswalk would need to be used to account for changes in format, content and meaning. The impact is ***medium***.

3. The Quality Improvement Organization Support Center (QIOSC) for prevention disparities will receive a data feed from the HAJI Part B database. The QIOSC will perform demographic stratification on the claims data to identify those beneficiaries who fall under the prevention disparity theme.

Impact:

- The QIOSC will be responsible for updating their system to accommodate the ICD codes supplied to them from HAJI Part B database. The impact is ***modest***.

4. The stratified claims data will be forwarded to the participating QIOs. The QIOs will perform analysis on the data to identify trends and calculate rates for diabetes care and treatment.

Impact:

- The data used by the QIOs to develop prevention disparities strategies relies on ICD codes. If the transition from ICD-9 to ICD-10 is not implemented accurately, the data supplied and stored in the HAJI database may not be accurate. If the QIOs relied on inaccurate data to identify prevention disparities trends their ability to identify and implement target activities will be negatively impacted. The impact is ***medium***.

5. The QIOs will provide OCSQ/QIG/DQIPCAC reports detailing the progress being made in meeting the objectives set forth in the prevention disparities theme. These reports will include:
    - Recruitment of Participating Practices (PPs) (submitted weekly until end of recruitment period)
    - Monthly completion reports (submitted monthly)
    - Statewide rates for all diabetes measures (submitted quarterly)
    - Diabetes education activities (submitted quarterly)
    - Baseline and PP level trends on diabetes (submitted annually)

Impact:

- OCSQ/QIG/DQIPCAC will receive the QIO progress reports and is responsible for evaluating the performance of the QIO in respect to the Prevention Disparities theme. Under the SOW, QIOs establishes baseline rates and are subsequently evaluated regarding their ability to work with providers to improve the rates. If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, OCSQ/QIG/DQIPCAC may be required to modify the contract. Additionally, the ability of OCSQ/QIG/DQIPCAC to accurately assess the QIO's performance may be affected if the measures have to be redefined as a result of the implementation of ICD-10. The impact is ***medium***.

Monitor Prevention: Chronic Kidney Disease (CKD)

1. OCSQ/ISG/DQSCM receives a monthly TAP file containing Part A and Part B data from NCH. The TAP file is loaded into HAJI Part A and Part B. The data will be used to identify and monitor beneficiaries who meet the identified criteria for the Prevention CKD theme.

Impact:

- OCSQ/ISG/DQSCM will be responsible for modifying HAJI Part A and Part B to accept and store the increased field length size of ICD-10 codes. Additionally, HAJI will need to be modified to accept both ICD-9 and ICD-10 codes. The impact is ***medium***

2. OCSQ/ISG/DQSCM will run algorithms on the data. The three primary measures for the Prevention CKD theme are:
    - Timely testing to reduce the rate of kidney failure due to diabetes
    - Slowing the progress of diabetes in individuals with diabetes through the use of ACE inhibitor and/or ARB agent and
    - Arteriovenous (AV) fistula placement and maturation as treatment option for kidney failure.

    Data analysis for the first two measures will be performed using claims data from HAJI. Data analysis for the AV fistula measure will rely on the HAJI data and form 2728. The 2728 form is completed by dialysis centers on each Medicare beneficiary and is provided to

OCSQ/QIG/DQIPCAC. OCSQ/ISG/DQSCM will obtain the 2728 forms to utilize in the calculation of this measure. The 2728 form contains a limited number of pre-determined ICD codes.

Impact:

- OCSQ/ISG/DQSCM will be responsible for rewriting the HAJI algorithms used to identify the measurement data for the prevention disparities theme. Each of the measures is identified by ICD-9 codes and will need to be rewritten to accommodate the respective ICD-10 codes. It is unclear how the analytic processes will handle measure periods that utilize both ICD-9 and ICD-10 codes. If coding schemes for both ICD-9 and ICD-10 are required a crosswalk would need to be used to account for changes in format, content and meaning. The impact is ***medium.***

- The 2728 form used for the AV fistula measure is completed by the dialysis facilities and is ultimately provided to OCSQ/ISG/DQSCM. If the 2728 forms are either incorrectly completed or not forwarded the rates for the AV fistula measure will be inaccurate. The impact is ***modest***

3. The QIOs will receive the analytic files and provide OCSQ/QIG/DQIPCAC reports detailing the progress being made in meeting the objectives set forth in the prevention CKD theme.

Impact:

- OCSQ/QIG/DQIPCAC will receive the QIO progress reports and is responsible for evaluating the performance of the QIO in respect to the CKD Prevention theme. Under the SOW, QIOs establishes baseline rates and are subsequently evaluated regarding their ability to work with providers to improve the rates. If the implementation of ICD-10 falls within the three year time frame of a QIO SOW, OCSQ/QIG/DQIPCAC may be required to modify the contract. Additionally, the ability of OCSQ/QIG/DQIPCAC to accurately assess the QIO's performance may be affected if the measures have to be redefined as a result of the implementation of ICD-10. The impact is ***medium***.

Process Risk Assessment

OCSQ/ISG/DQSCM is responsible for the collection and distribution of data to support QIO activities. This effort requires OCSQ/ISG/DQSCM to have the ability to receive and process Medicare data from numerous sources. OCSQ/ISG/DQSCM will have to rely on other components within CMS to provide data that has been accurately updated to reflect the changes between ICD-9 and ICD-10 codes. In addition, OCSQ/ISG/DQSCM will be responsible for updating the systems they own to accommodate ICD-10 codes. These systems, including the Administrative Warehouse, HAJI, Care Transitions Database and CRIS are used to capture and synthesize the raw Medicare data provided by data feeds from other CMS components. Various analytic file are then supplied to the QIOs who will use the data, and included ICD codes, to improve quality of care, protect the Medicare trust fund, and address beneficiary complaints. If the systems owned by OCSQ/ISG/DQSCM are not accurately updated, the ability of the QIOs to meet their objectives, as outlined in the 9th SOW, will be negatively impacted. The risk to OCSQ/ISG/DQSCM is ***medium***[43].

[43] A Medium or Orange Level Process may be interrupted without complete stoppage

OCSQ is responsible for overseeing the QIO program. This includes the development of the QIO SOW which outlines the roles and responsibilities for the QIOs. The themes contained in the QIO SOW are the responsibility of different components within OCSQ. OCSQ/QMHAG/DPACC is responsible for Care Transitions; OCSQ/QIG/DQIPAC is responsible for the Patient Safety and Beneficiary Protection themes; and OCSQ/QIG/DQIPCAC is responsible for the prevention themes. The QIO contractors work under a three year contract and follow the clearly defined requirements outlined in the SOW. If the transition to ICD-10 codes falls in the middle of a QIO contract period, the divisions within OCSQ may be required to modify the SOW. These updates would reflect the possible changes to the QIO's responsibilities resulting from the transition to ICD-10. Additionally, QIOs are responsible for providing periodic feedback reports to OCSQ detailing progress made in meeting their objectives. OCSQ uses these reports to measure the ability of each QIO to meet their required tasks and objectives. The transition from ICD-9 to ICD-10 poses a risk to the QIOs to generate accurate feedback reports. The QIOs rely on CMS supplied data to meet their objectives. The receipt of inaccurate or delayed data, due to other CMS components improperly transitioning to ICD-10, could prevent the QIOs from accurately reporting their progress. OCSQ could be unable to accurately measure QIO performance in meeting their requirements. The risk to this process is ***modest***[44].

[44] A Modest or Yellow Level Process will continue with intermittent modifications to the process

Appeals Process
Impact Rank: Medium
Process Summary Report

Table 11 - Process Summary Report ICD-10 Implementation Impact Ranking:

Appeals Process Rank: Medium[45] or Orange Level	Center for Beneficiary Choices (CBC)/ Medicare Enrollment & Appeals Group (MEAG)/ Division of Appeals Operations (DAO): Medium or Orange Level	Center for Beneficiary Choices (CBC)/ Medicare Enrollment & Appeals Group (MEAG)/ Division of Appeals Policy (DAP): Minor[46] or Green Level	The Office of Information Services (OIS)/ Business Applications and Management Group (BAMG): Modest[47] or Yellow Level

Process Overview

The purpose of the Appeals Process is to provide Medicare beneficiaries and their providers a formal process to dispute a claim or coverage determination. If dissatisfied with an initial coverage determination (denial of coverage or payment), a beneficiary, his or her representative, or a provider of service may request an appeal of a decision. There are five levels of review available which are together referred to as the "appeals process."

The Medicare Enrollment & Appeals Group (MEAG), which resides within the Center for Drug and Health Plan Choice (CPC), is responsible for appeals policy and operations. MEAG has two divisions overseeing policy and operations for the appeals process. The Division of Appeals Policy (DAP) develops appeal policy for Fee-for-Service (FFS), and oversees the operations for Medicare Advantage (MA) Part C and the prescription drug benefit (Part D). DAP develops regulations, beneficiary notices, and policies associated with Part A, B, C, and D appeals. The Division of Appeals Operations (DAO) oversees FFS appeal operational activities including direction to the ACs and the QICs. In addition, the reopening process allows plans and appeals adjudicators to reopen decisions to correct denials.

The Centers for Medicare & Medicaid Services (CMS) contracts with external entities to perform processing functions on behalf of Medicare. Under the FFS program, initial claims processing determinations and first level appeal reviews are conducted by Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), and Carriers further defined as Affiliated Contractors (ACs). Second level appeals under FFS are conducted by Qualified Independent Contractors (QICs). Under the Part C program, Medicare Advantage (MA) Plans are responsible for the first level of appeal. Under the Part D program, Medicare Prescription

[45] A Medium or Orange Level Process will have an impact that, if the impact occurs, will cause noticeable cost (and/or schedule) increases to the project.
[46] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.
[47] A Modest or Yellow Level Process will have an impact that, if the impact occurs, will cause small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

Drug Plans (MA-PDs and PDPs) are responsible for the first level of appeal. Under Parts C and D, the independent review entity (IRE) processes the second level appeals.

ICD-9 codes reside in each step of the appeals process. CMS directly oversees the first and second levels of appeal. Other levels of appeal are outside of the CMS jurisdiction/control although level three appeals are tracked in the MAS system.

The QICs and IREs utilize the Medicare Appeals System (MAS) to collect and maintain information necessary to track the level two and level three appeal requests. The Office of Information Services' (OIS) Business Applications and Management Group (BAMG) is the system owner for MAS, and MEAG is the primary business owner. Information recorded in MAS includes appeal status, case type, case history, timely resolution tracking, decision letters, and all other correspondence related to a case. Currently, MAS users with the QICs, Part C IRE, and Administrative Law Judges (ALJs) at OMHA enter ICD-9 codes into MAS. The ICD-9 codes in MAS have an assigned field and are presented for selection via drop-down menus. Other entities may enter data into their own case tracking systems residing outside of CMS control. Outside systems are not within the scope of this project.

MAS implemented an interface on September 15, 2008 which utilizes an integration layer created by the Next Generation Desktop (NGD) team. The interface provides automated processes for pulling beneficiary and claim data into MAS. Beneficiary data comes from the Medicare Beneficiary Database (MBD) and the Enrollment Database (EDB). Beneficiary data is unrelated to ICD-9 codes. Claim data, including ICD-9, comes from the CMS Shared Systems: Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS) and ViPS Medicare System (VMS).

The impact of transitioning to ICD-10 for the MAS is modest. MEAG will work with the appropriate CMS components to determine the best method(s) of incorporating ICD-10 codes into the new interface as well as the MAS and database for FFS appeals. MEAG must make decisions and implement changes to the MAS to ensure continued reporting capabilities for periods of time where appeal information containing ICD-9 and ICD-10 codes may overlap or contain only historical ICD-9 codes. System crosswalks and tables were discussed as possible solutions. MEAG believes the new interface and existing database fields will be able to accommodate the extended character length and alpha characters required to accommodate ICD-10 codes coming from the shared systems. Further investigation will be required in order to conclude all aspects of the impact of the transition.

The impact to FISS, MCS and VMS are continued in the Part A and Part B claims processing process summary reports.

Related Processes

1. Congressional mandates and legislation are inputs into the appeals process. DAP and DAO create policy and operational changes as outputs to the ACs and the QICs/IREs. The Office of Clinical Standards and Quality (OCSQ) and MACs develop Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), which are applied to making appeal decisions. LCDs and NCDs contain ICD-9 codes.
2. The new interface to MAS will input data, including ICD-9 codes, from the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS) and ViPS Medicare System (VMS). Enrollment and beneficiary data will also come from the MBD and EDB.
3. Users within the QICs, IREs and ALJs input data directly into MAS. ICD-9 data is included as an input.
4. Output from MAS is in the form of reports to be used within MEAG, the Office of External Affairs' Medicare Ombudsman Group (MOG), and contracted safeguard contractors as needed.

Process Description

Policy Development for Appeals Adjudication

1. The process of policy development begins when Congress mandates legislation and rules.
2. The CMS Division of Appeals Policy (DAP) develops regulations and policies as they relate to Parts A, B, C and D appeals processes.
3. The Medicare coverage policy is also based on medical necessity. MEAG uses Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) because the LCDs and NCDs help determine medical necessity, as MEAG's policies are driven by the LCDs/NCDs.
4. Local and National Coverage Decisions and other legislative prospective payment system (PPS) policies are the basis for claim payment rules. Claim payment rules are applied to help determine the result of an appeal case. ACs develop the LCDs and the Office of Clinical Standards and Quality (OCSQ) develops the NCDs. LCDs and NCDs contain ICD-9 codes and, for Parts A & B claims, are applied to decision rules for each level of the appeal process.

Impact: The impact of transitioning to ICD-10 for the Policy Development and Implementation Process and Part C and D programs is ***minor***. The Division of Appeals Policy (DAP) identified regulation interpretation and policy updates as areas that must accommodate a transition to ICD-10. It is expected this will be managed as a part of the every-day work. The Division of Appeals Policy will require the implementation timeline to ensure policy changes and instructions are effectively coordinated in advance of the go-live date.

Conduct Appeals

FFS (Part A & B) Claims

1. The appeal process begins with the Claims Process when a provider submits a claim to an AC. The claims detail is continued in the Part A and Part B claims processing process summary reports.
2. The claim is adjudicated by the AC and is either paid or denied/rejected. The claims detail is continued in the Part A and Part B claims processing process summary reports.
3. The AC returns a message (Remittance Advice (RA) to the provider and a Medicare Summary Notice (MSN) to the beneficiary) indicating claim payment or non-payment. The claims detail is continued in the Part A and Part B claims processing process summary reports.
4. The provider, beneficiary or beneficiary representative disputes the outcome of the claim and enters the "first level" of the appeal process by sending in a request for redetermination.

Impact: The impact of transitioning to ICD-10 for Conduct Appeals related to FFS claims is ***modest***. ICD-9 codes are required for making a claim determination. If, after the implementation of ICD-10, claims are submitted with incorrect codes or adjudicated incorrectly by a claims processing system, there is a potential for a significant increase in the number of claim appeals filed. Provider education and successful ICD-10 updates to claim processing systems will help to ensure claims are submitted with correct codes. These areas of responsibility are outside of MEAG's responsibilities.

Medicare Advantage Plans (Part C) and Prescription Plan (Part D)

1. The appeal process begins after a plan has denied coverage or payment for a service or a prescription drug.
   a. Medicare Advantage Plans (Part C) services may involve both Pre Service and Payment denials.
2. If the beneficiary, beneficiary representative or non-contracted provider disputes an initial coverage decision, they may enter the "First Level of Appeal" process.
   a. For a retrospective payment request, Medicare Advantage Plans have a 60-day time limit to notify the enrollee of its decision. For a standard pre-service request, the MA plan has 30 days to notify the enrollee of its decision. For an expedited pre-service request, the MA plan has 72 hours to notify the enrollee of its decision.
   b. For standard appeals, prescription drug plans must notify the enrollee of its decision within 7 days. For expedited appeals, prescription drug plans must notify the enrollee of its decision within 72 hours.

Impact: The impact of transitioning to ICD-10 for Conduct Appeals related to Part C and D is ***modest***. ICD-9 codes are required for making a coverage or payment determination for Part C. ICD-9 codes are not included in Part D. If, after the implementation of ICD-10, coverage or payment requests are submitted with incorrect codes or adjudicated incorrectly, there is a potential for a significant increase in the number of appeals filed.

First Level of Appeal: Redetermination by a Medicare Contractor or Plan

FFS (Part A & B) Claims

1. A beneficiary, provider or authorized beneficiary representative sends a written request for a "re-determination" to the AC, also called a "first level" appeal.
   a. The requestor has 120 days from the date of the initial determination to file their request.
   b. There is no minimum monetary threshold to prevent a first level appeal.
2. The AC decides in favor of the appeal or the appeal is denied.
   a. If ruled in favor of appeal, the AC adjusts and pays the claim, also referred to as "effectuation."
   b. If denied, the requestor may make a second level appeal to the QIC by submitting a request for reconsiderations.
3. The requesting party is notified in writing with the appeal result.

Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D)

1. A beneficiary, non-contracted provider (Part C), prescriber (Part D) or authorized beneficiary representative sends a written request for a "reconsideration" to the Medicare Advantage plan or a request for "redetermination" to the prescription drug plan (referred to herein as the Plan), also called a "first level" appeal.
   a. There is no amount in controversy requirement for a first level appeal.
2. The Plan decides in favor of the appeal or the appeal is denied.
   a. If the decision is favorable, the plan must cover the service/drug or make payment.
   b. If denied, or the requestor does not receive a response within the time limit, the requestor may request a Second Level Appeal.
      i. Medicare Advantage Plans have a 60-day time limit to notify the enrollee of its decision. For a standard pre-service request, the MA plan has 30 days to notify the enrollee of its decision. For an expedited pre-service request, the MA plan has 72 hours to notify the enrollee of its decision.

ii. For standard appeals, Prescription drug plans must notify the enrollee of its decision within 7 days. For expedited appeals, prescription drug plans must notify the enrollee of its decision within 72 hours.

3. The requesting party is notified in writing with the appeal result.

Impact: The impact of transitioning to ICD-10 for first level appeals is ***minor***. Plans and the IREs are responsible for their employee training, business processes and application updates in order to accommodate ICD-10. However, during the transition an increase in coverage and payment denials may occur. As a result, an accelerated impact may be felt by MEAG if the numbers of appeals increase, raising the impact to medium. For Part C and D Plans, the impact also relates to accuracy of coding and reporting during the transition. The increase in the number of codes and a change to the Hierarchical Condition Categories (HCCs) for Plans may cause the same types of denials to occur. In advance of the transition to ICD-10, MEAG will need to work with Plans to ensure issues related to coding errors are identified and resolved before applying the new codes to the appeal process. This will entail policy updates, communications and training plans.

Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)

FFS (Part A & B) Claims

MEAG directly oversees second level appeals.

1. The second level appeal is requested in writing and sent to a QIC.
   a. The request must be sent within 180 days from the AC's first level appeal reconsideration decision.
   b. QICs are contracted by MEAG to provide impartial appeal decisions outside of the AC's operations.
   c. The QIC has 60 days to send its decision.
2. Appeal case information is entered into the MAS for tracking. ICD-9 information is included in the case information.
3. The appeal is ruled in favor of the appellant or it is denied by the QIC.
   a. If ruled in favor of appeal, the appeal decision is returned to the AC and adjusted to reflect the claim correction.
   b. If denied, or the QIC does not respond within 60 days, the requestor may make a third level appeal request.
4. The requesting party and the AC are sent written notification of the appeal decision.
5. Appeal information is entered into MAS by QICs.

Managed Care (Part C) and Prescription Plan (Part D)

1. The Plan decides in favor of the appeal or the appeal is denied.
   a. If the decision is favorable, the plan must cover the service/drug or make payment.
   b. If denied, or the requestor does not receive a response within the time limit, the requestor may make a Second Level Appeal. Under Part D, if the plan doesn't make a timely decision, it must auto-forward the case to the IRE. Under Part C (as noted above), if the plan's decision is unfavorable, it must auto-forward the case to the IRE.
      i. For a retrospective payment request, the Part C IRE must notify the enrollee of its decision within 60 days. For a standard pre-service request, the Part C IRE has 30 days to notify the enrollee of its decision. For an expedited pre-service request, the Part C IRE has 72 hours to notify the enrollee of its decision.
      ii. The Part D IRE must notify the enrollee of its decision within 7-days for a standard request and within 72-hours for an expedited request.
2. The second level appeal is requested in writing and sent to an Independent Review Entity (IRE).
   a. IREs are contracted by MEAG to provide impartial appeal decisions outside of the Plan's operations.
   b. The request for a second level appeal must be sent within 60 days from the prescription drug plan's redetermination decision. Under Part C, if the first level of appeal (reconsideration) decision is unfavorable, the case is automatically sent to the IRE for review.
3. The IRE sends written notification of the appeal decision to the requesting party and the Plan.
4. Appeal information is entered into MAS by IRE staff. IREs also utilize internal tracking systems. At this time, it is not known if they capture ICD-9 codes in their internal systems.

Impact: The impact of transitioning to ICD-10 for Second Level Appeals is ***modest***. In FFS Appeals, in-depth training will be required for QIC employees in order to ensure their full understanding and ability to interpret ICD-10 code impacts on existing and new appeal cases. FFS QIC employees are trained through MEAG Administrative QIC (AdQIC) contractor (Q^2 Administrators). Although MEAG holds monthly one-hour calls with QICs, the calls are not sufficient for the level of training required. Currently, annual or regular training on ICD-9 does not occur and the number of QIC employees to be trained is not yet known.

Providing knowledgeable coding staff is part of the CMS contract with IREs. Currently MEAG believes the costs associated with additional training are expected to be absorbed by the IRE as a cost of doing business by providing coding experts. The impact to MAS is identified in the Process Overview.

Third Level of Appeal: Hearing by an Administrative Law Judge (ALJ)

The ALJs operated under Health and Human Services' (HHS) Office of Medicare Hearings and Appeals (OMHA). ALJs are not under direct oversight of MEAG. There are four regional offices for ALJ: Arlington, VA; Cleveland, OH; Irvine, CA and Miami, FL.

FFS (Part A & B) Claims

1. Appellants send a written request for ALJ hearing to all parties of the reconsideration.
   a. At least $120 must remain in controversy following the QIC's decision (the dollar amounts given are subject to change annually).
   b. Any party to the reconsideration may request an ALJ hearing.
   c. The request must be made within 60 days of receipt of the reconsideration decision.
2. The ALJ decides in favor of or against the appeal.
   a. The ALJ will generally issue a decision within 90 days of receipt of the hearing request.
   b. If the ALJ cannot issue a decision in the applicable timeframe, the ALJ will notify the appellant of their right to escalate the case to the Appeals Council located at the Departmental Appeals Board.
   c. If ruled in favor of appeal, the appeal decision is returned to the AC and adjusted to reflect the claim correction.
3. The requesting party, QIC, and the AC are sent written notification of the appeal decision.
   a. If any of the parties are not satisfied with the decision of the ALJ, a fourth level appeal may be requested.
4. ALJ employees enter appeal information into the MAS.

Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D):

1. Appellants have 60 days to send a written notice to the ALJ hearing request to all parties for reconsideration.
   a. At least $120 must remain in controversy following the IRE's decision (the dollar amounts given are, by law, re-calculated annually).
   b. Any party to the reconsideration may request an ALJ hearing.
   c. The request must be made within 60 days of the reconsideration decision.
2. Case information is entered into the MAS for tracking. ICD-9 information is included in the case information.
3. The ALJ decides in favor of or against the appeal.
   a. There are no time limits applied to Managed Care Appeals.

b. There is currently no time limit for adjudicating Part D appeals at the third level of appeal.

c. If the decision is favorable, it is sent to the Plan for effectuation.

4. The ALJ sends a written decision notification to the requesting party, IRE and Plan. If a party is not satisfied with the decision of the ALJ, a fourth level appeal may be requested.
5. Appeal information is entered into the MAS.

Impact: The impact of transitioning to ICD-10 for third level appeals is ***modest*** because they enter information into MAS and MAS relies on the shared systems. The impact to MAS is identified in the Process Overview. ALJ staff will require training, and their internal systems may be impacted, but this portion of the process exists outside of CMS and its contractors. Even though OMHA is outside of MEAG purview, an effective appeals process involves collaboration with partners; thus, MEAG may consider communication to this office regarding expected impacts.

Fourth Level Appeal: Review by the Appeals Council

FFS (Part A & B) Claims, Managed Care (Part C) and Prescription Plan (Part D):

The Appeals Council operates under the Departmental Appeals Board (DAB) of the Department of Health and Human Services (HHS) and is not under direct oversight of MEAG.

1. Fourth level appeals must be submitted in writing within 60 days of receipt of the ALJ's decision by a party to the hearing or may be referred to the DAB by CMS.
   a. There is no minimum monetary threshold requirement for money in controversy.
2. Appeals Council decides on claim appeal.
   a. Issues decision within 90 days of receipt of a request for review. The DAB has independent discretion on whether or not to accept a referral by CMS.
   b. If the decision is favorable, it is sent to the Plan for effectuation.
   c. If the parties are not satisfied with the decision, the parties may request a fifth level appeal.
3. All parties are sent written notification of the appeal decision.
4. The Appeals Council uses the Medicare Operations Division Automated Case Tracking System (MODACTS) for tracking their appeal cases. At present, there is no information about MODACTS. Although the system may contain ICD-9 codes, it is believed MODACTS is operated outside of the CMS purview. Therefore, it is out of scope at the time of this writing.

Impact: The impact of transitioning to ICD-10 for fourth level appeals is ***minor***. Appeals Council staff will require training, and their internal systems may be impacted, but this portion of the process exists outside of CMS and its contractors. The activities performed by the

Appeals Council are under the oversight of HHS and do not have a direct impact on CMS unless there is a complete failure of the Medicare Appeals Council to complete appeals cases. Since this is not a likely scenario, the projected impact is minor. Even though the Appeals Council is outside of MEAG purview, an effective appeals process involves collaboration with partners; thus, MEAG may consider communication to this office regarding expected impacts.

Fifth Appeal Level: Judicial Review in Federal District Court

FFS (Part A & B) Claims

1. The appellant must present a written request for a Federal District Court hearing.
   a. Monetary threshold = $1,180 or more must remains in controversy following the Medicare Appeals Council's decision.
   b. Appeal requested within 60 days of receipt of the Medicare Appeals Council's decision.

2. Judicial Review decides on claim appeal.
   a. If ruled in favor of the appeal, the appeal decision is returned to the AC for effectuation.
   b. If the parties are not satisfied with the decision, there is no further action to be taken.
3. All parties are sent written notification of the appeal decision.
4. The courts use tracking systems, outside of CMS, to track cases. Internal applications may house ICD-9 codes. However, these systems are out of scope for this project.

Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D)

1. The appellant must present a written request for a Federal District Court hearing.
   a. Monetary threshold = $1,180 or more must remain in controversy following the Appeals Council's decision (the dollar amounts given are, by law, re-calculated annually).
   b. Appeal requested within 60 days of receipt of the Appeals Council's decision.
2. Judicial Review decides on claim appeal.
   a. If the decision is favorable, it is sent to the plan for effectuation.
   b. If the parties are not satisfied with the decision, there is no further action to be taken.
   c. All parties are sent written notification of the appeal decision.
3. The courts use tracking systems, outside of CMS, to track cases. Internal applications may house ICD-9 codes. However, these systems are out of scope for this project.

Impact: The impact of transitioning to ICD-10 for fifth level appeals is ***minor***. The activities performed by the Federal District Court are outside the purview of CMS. Their activities do not have a direct impact on CMS unless there is a complete failure of the Federal District Court to complete appeals cases. Since this is not a likely scenario, the projected impact is minor. Even though the Federal District Court is outside of MEAG purview, an effective appeals process involves collaboration with partners; thus MEAG may consider communication to them regarding expected impacts.

Collect and Maintain Information Relevant to an Appeal Process

1. Using data from MAS, the QICs/IREs perform data analysis and trending from which reports are generated. Reports may include ICD-9 codes. MEAG requires the ability to track data (including ICD codes) across multiple fiscal years.
2. MEAG shares data with other CMS areas such as the Office of External Affairs (OEA), Medicare Ombudsman Group (MOG). Data is also shared with external Safeguard Contractors on fraud initiatives as necessary.

Impact: The impact of transitioning to ICD-10 for the Collect and Maintain Information Relevant to an Appeal Process is ***modest***. Standard and ad hoc reports are generated from MAS. To ensure report data quality, MEAG must work with the appropriate CMS components to determine the best method(s) of incorporating ICD-10 codes into the new interface as well as their current MAS and database. MEAG expects to make decisions and implement changes to supporting reporting methods to continue reporting capabilities for periods of time where appeal information containing ICD-9 and ICD-10 codes may overlap or contain only historical ICD-9 codes. System crosswalks and tables were discussed as possible solutions. MEAG believes the new interface and existing database fields will be able to accommodate the extended character length and alpha characters required to accommodate ICD-10 codes. Further investigation is required to conclude all aspects of the transition.

Process Risk Assessment

Increase in Appeals

Although individual activities are designated with a moderate to minor impact, the transition to ICD-10 presents a ***medium***[48] risk to the appeal process and systems. A ***medium*** risk is assigned based on the potential increase in the number of appeal cases caused by a failure to successfully implement ICD-10 by ACs and providers. ICD-9 codes are a required data element for FFS claim adjudication. Failure by ACs to fully implement ICD-10 in their claims and business rules will result in a significant increase in denied and incorrectly paid claims. Typically, ACs resolve claim issues resulting from coding errors through the claim "reopening"

[48] A Medium or Orange Level Process may be interrupted without complete stoppage.

process and the claims do not enter the appeal process. Claims issues causing coding errors should not cause an appeal. However, there is a potential for a significant number of claims to enter the appeal process if not identified by the ACs, up front, as claims to be resolved through the appeals process. Claims incorrectly entering the appeal process will cause a workload increase (volume not specified) to QICs and IREs, which in turn may lead to an increase in contractor costs.

Additionally, almost every level of the appeal process has specific time limits to respond to an active appeal. An unanticipated increase in appeals (resulting from claims that should have been resolved through the reopening process) may create a backlog of cases to be reviewed. An unplanned backlog may result in failure to meet mandated response times.

Medicare Policy

Medicare policy, such as LCDs and NCDs are the basis for redetermining the status of an appeal. MEAG uses the LCDs and NCDs to help determine medical necessity since MEAG's policies are driven by the LCDs/NCDs. Therefore, there is a risk to MEAG if medical necessity policies are not updated correctly and timely.

Implementation Timing

Implementation timing may also present a risk to MEAG. When ICD-10 is implemented, parallel systems (containing both ICD-9 and ICD-10) will not be available for case tracking or reporting. Therefore, appeal cases filed prior to ICD-10 implementation will contain ICD-9 codes for approximately one year after the transition to ICD-10. This has been noted by MEAG and a crosswalk will be applied. MEAG notes the need to consider the claim at the time it is initially submitted. The risk to MEAG occurs when going back to a favorable appeal, a method needs to be found during processing to make an adjustment. Because of the timing issues to the appeals process, MAS would need to contain both ICD-9 and ICD-10 codes for a period of time.

Medicare Appeals System

If the Medicare Appeals System is not updated to accept ICD-10 codes and integrated with existing ICD-9 codes, MEAG will not have the ability to report, track or analyze appeal information. Further, similar Shared Systems changes are also required to ensure accurate claims data provided through the appeals system interface. If the Shared Systems are not updated appropriately, the interface will provide inaccurate ICD information to the appeals system. MEAG anticipates the field length of the MAS will need to change. MEAG anticipates making consistent changes to MAS being made to the Shared Systems. For example, if an extra field is added to the Shared Systems, then an extra field would be added to MAS; if the field is replaced, then the extra field will be filtered in MAS, keeping the old one.

Data Analysis and Trending

MEAG and its contractors perform data analysis and trending, resulting in reports including ICD-9 data. MEAG must be able to track data across the entire fiscal year. MEAG trends data from year to year in order to analyze information such as contractor workload. ICD codes are linked to this data. MEAG anticipates using crosswalks, but the data mapping between ICD-9 and ICD-10 is not a one-to-one match. Some ICD-10 codes will be expanded (or offer more than one choice) for what is currently a single ICD-9 code. In other cases, a single ICD-10 code may combine multiple ICD-9 codes. This is a complex process. Mappings between ICD-9 to ICD-10 can be "one-to-one," "one-to-many," "many-to-one" or may not map at all. Implementation and interpretation of the maps will require personnel with a skilled knowledge of ICD-9 and ICD-10 and many hours will be required to interpret the data produced from such maps. Case files are also maintained indefinitely. Therefore, a method to crosswalk data between the two code sets may be required. Data comparability will also be affected because of the differences in the code systems. Maintenance of maps among coding systems is necessary for longitudinal data analysis, and the ability to conduct trend analysis is compromised or difficult because of structural changes in the two systems.

Training

QIC and IRE training may provide a further risk. The Administrative QIC (support contractor to other QICs) would provide training to the FFS QICs utilizing materials produced by CMS. It is anticipated that computer-based modules with links to other materials would be used. Currently the AdQIC provides training for new employees, updates (new MAS releases), protocols (high level diagrams of how to process an appeal), more detailed manuals (taking the protocols and applying them at a much more detailed level of how the process works), and template operating agreements of how the QICs work with ACs, AdQIC or OMHA offices). The AdQIC also provides all standard reports and ad-hoc reports QICs run from MAS. Currently the AdQIC does not have a specific module on ICD-9 codes; they assume contractors have a general knowledge of basic coding and the application of policy to appeals. When this type of training is needed, the individual QIC provides it to their employees. In the case of the transition to ICD-10, the AdQIC would provide training because ICD-10 is new. The AdQIC anticipates using a general module to orient all QICs regarding ICD-10. The adjudicators are the ones using codes, and there will not be a need to know how to code, just how to apply the disease condition to the case and how it related to the LCD/NCD being applied; the code and the description of the code are provided.

For Part C appeals, the IRE enters codes by utilizing drop-down menus of all current ICD-9 codes. The analyst (coder) selects the correct code for the issue in dispute (primary diagnosis). Direct code entry is not possible. During the update of MAS, a further risk may involve the numbers of codes. Currently ICD-9 has 18,000 diagnosis codes; ICD-10-CM has 55,000 more or about 68,000 diagnosis codes. This may be significant when selecting codes from a drop-down list. Instead of utilizing drop-downs, free text may be needed. Currently, ICD-9 codes are not captured in Part D cases, but the IRE plans to begin capturing diagnosis codes in the future. The IREs will be responsible for ensuring that its staff is properly trained in the use of the new codes.

Inadequate or improper training poses a risk to MEAG. Since the ICD-10 system is different (especially ICD-10-PCS), contractors and anyone involved in making determinations involving claims or appeals must fully understand the changes, and be able to correctly analyze and apply the maps available.

Coordination of Benefits Agreement Process Impact Rank: Medium

Table 24. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Coordination of Benefits Agreement (COBA)Process **Medium**[49] **(Orange Level)**	Office of Financial Management (OFM)/ Financial Services Groups (FSG)/ Division of Medicare Benefit Coordination (DMBC) **Medium** **(Orange Level)**

Process Overview

The Coordination of Benefits Agreement (COBA) process documents the eligibility and Medicare claims payment information exchange between CMS and supplemental insurers as well as the process for insurers to supply additional insurance to Medicare beneficiaries. The COBA process allows supplemental insurers to send eligibility information to CMS and provides those insurers Medicare paid claims data from CMS for processing supplemental insurance benefits. The Coordination of Benefits Contractor (COBC) manages this national program for CMS and the Office of Financial Management (OFM)/Financial Services Group (FSG)/ Division of Medicare Benefit Coordination (DMBC) manages and provides direction to the COBC with respect to COBA. The COBC is responsible for managing the relationship between supplemental insurers/payers and CMS, collecting the necessary payer and beneficiary eligibility information, and distributing adjudicated claim data from CMS to the appropriate supplemental payer. The COBC provides the claims information to supplemental payers in the standard Healthcare Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 compliant format.

The COBC collects beneficiary eligibility information from supplemental payers and sends this eligibility information to the Common Working File (CWF) at least monthly or as often as bi-weekly. The CWF is owned and maintained by the Office of Information Systems/Division of Business Application Analysis. As CWF reviews incoming claims from Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DMACs) for verification and validation, CWF notifies MACs and DMACs when it finds beneficiary eligibility and insurer specific information in association with claims that are targeted for crossover to the COBC. Coordination of benefits (COB) flat files containing claims for beneficiaries with other insurance are sent from the CMS claims processing systems, Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), and VIPS (Viable Information Processing Systems) Medicare System (VMS), to the COBC. The COBC converts the claims from a flat file format to a HIPAA compliant format for electronic transmission to supplemental payers. COBC uses its Ingenix/Claredi HIPAA translator product to support this step in the process. The claims sent from the claims processing systems contain ICD codes, as

[49] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

well as other codes allowable within the transaction code set. The COBC activities include review and evaluation of ICD codes in claims sent from the claims processing systems.

The primary impacts of ICD-10 implementation in this process will affect the crossover portion where claims are sent from CMS's Medicare claims processing systems to the COBC and the COBC translation and validation of the claims comes into play before sending them to supplemental payers. The COBC uses the Ingenix/Claredi HIPAA translator to translate claims into the HIPAA American National Standards Institute (ANSI) 837 institutional and professional format and then validates the compliance of the translated claims before transmitting the claims to COBA trading partners. This application will require modification and updates to accommodate ICD-10 codes.

Related Processes

The COBA process is connected to the Claims Processing processes for Medicare Part A and Part B as well as Durable Medical Equipment (DME). The COBA process collects data on beneficiaries with other insurance used by the claims processing systems, FISS, MCS and VMS, and those systems send claims for those beneficiaries to the COBC for distribution to supplemental payers.

Process Description

1. Supplemental insurers/payers enter into a COBA with the COBC. The COBC manages this relationship for CMS, and OFM/FSG/DMBC provides direction for the COBC. This agreement will allow the supplemental payers to receive claims electronically from the crossover process. The payer will supply the COBC with the types of claims it wants to receive and is responsible for providing updates on changes in the payer's beneficiary eligibility status. The COBC captures the types of claims that the payer expects to receive, along with other information, within the COBC Data Store. There are no ICD codes involved in this step.

   Impact: No Impact.

2. On a regular basis, the supplemental payers submit information to the COBC on the payer's eligible beneficiaries who are also eligible for Medicare coverage. This list may update status of existing beneficiaries or add new beneficiaries with supplemental insurance. This file is called the COB eligibility record (or E-01) and contains information on the beneficiary and his/her status. There are no ICD codes. The COBC receives the E-01 eligibility record and performs an acknowledgement and two levels of editing.
   - The COBC sends an acknowledgement of receipt to the supplemental payer.
   - For the first level of editing, the COBC examines the file format to determine if the file is valid or has errors. The COBC provides the response to the payer. The payer would need to correct and re-submit files with errors.

- For the second level of editing, the COBC sends the incoming E-01 as a Beneficiary Other Insurance (BOI) or HUBO transaction to CWF, where CWF compares the incoming BOI with its internal criteria for matching purposes. Inaccurate information is marked and errors are reported to the payer. All accurately matched beneficiary information is stored and used in subsequent steps.

The COBC stores the beneficiary status updates in the COBC Data Store. There are no ICD codes involved in this step or stored in the COBC Data Store.

Impact: No Impact.

3. The COBC derives the beneficiary eligibility and claim selection criteria information from the COBC Data Store and formats the data to be submitted to the Common Working File (CWF). The CWF is owned and maintained by the Office of Information Systems (OIS)/Division of Business Application Analysis (DBAA). The COBC builds the BOI Auxiliary File (or HUBO transaction) and the COBA-Insurance File (COIF) to submit to CWF. The BOI Auxiliary File contains information on beneficiary eligibility and COIF contains the claim selection criteria information regarding the claim types that payers want to receive. This information will be utilized to crossover or send the appropriate claims from the claims processing system to the COBC, which will distribute the claims to the correct supplemental payers. There are no ICD Codes involved in this step or stored in the COBC Data Store.

   Impact: No Impact.

4. The CWF applies edits to the incoming BOI Auxiliary file or HUBO and treats the COIF as a full-file replacement transaction. CWF then sends beneficiary eligibility matching errors (termed “BO” errors and “SP” edits) back to the COBC. CWF loads the accurately matched beneficiary crossover eligibility information and overlays the claims selection criteria information received from the last COIF update. The beneficiary information identifies the beneficiary as having other insurance and the dates of coverage. Eligibility transaction and COIF input are necessary to set up the beneficiary, along with the types of claims to be selected in CWF, thereby ensuring that claims for beneficiaries with other insurance are loaded in CWF, those claims are forwarded to the COBC for processing.

   The COBC will forward those errors provided by CWF and errors they’ve identified to the payers in the Eligibility Response File (ERF). There are no ICD Codes involved in this step.

   Impact: No Impact.

Note: At this point in the process, the activities in steps 5 and 6 are part of the routine Part A and Part B claims processing process and will be fully described with impacts in the claims processing summaries. The COBA process provides inputs to claims processing following claim adjudication by contributing BOI Auxiliary File and COIF updates. The

process also receives claims as an output from the Medicare claims processing cycles. The steps from the claims processing process are described briefly in the COBA process. For full description, impact, risk and cost, refer to claims process summary reports.

5. CWF receives claims processed through the Medicare claims processing systems, FISS, MCS and VMS. CWF reviews the claim and provides approval for payment. In addition, CWF matches beneficiaries from the received claims with beneficiaries listed in BOI Auxiliary File from COBC and the information about the supplemental payer's selection criteria from the COIF. CWF builds a trailer (29) that it sends to the contractors' claims processing systems for the purpose of identifying the claims for beneficiaries with supplemental insurance that are to be crossed over. The trailer (29) is sent along with the CWF approval decision (01 disposition) and other relevant trailers to the appropriate claims processing systems.

   Impact: Impact included in the Part A and Part B claims processing summary report.

6. The Part A and Part B claims processing systems use the trailer (29) to determine which claims to send to COBC. The claims processing system builds a flat-file containing copies of the appropriate claims and sends the flat-file (called the 837 COB flat file) to the COBC. This flat file contains ICD codes.

   Impact: Impact included in the Part A and Part B claims processing summary report.

7. The COBC receives a copy of the paid claim record from each of the claims processing systems. These claims files have ICD codes.

   Impact:
   - The 837 COB flat file containing paid claims received by the COBC from the claims processing systems will require updating to accommodate ICD-10 codes. The COBC will have to update existing processes and systems to receive the modified file containing expanded ICD codes. This impact is ***minor***[50]**.** The claims data are provided in a flat file, limiting the scope of any changes required by the COBC. In addition, the COBC will have to make changes to its internal business edit processes and Ingenix/Claredi HIPAA translator product to accommodate the new HIPAA 5010 standard, which will precede the transition to ICD-10. The HIPAA 5010 format already accommodates additional spacing for the ICD-10 codes.

8. The COBC inbound system reviews the 837 flat file and its contents to confirm it contains the data structure (loops and segments) needed to build the HIPAA ANSI-X12-N 837 file to be sent to supplemental payers. If there are errors, the COBC logs them in

[50] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

the Detailed Error Report (DER) to the affected Medicare contractor (MAC or DMAC) that processed the claim. These kinds of errors are termed "111" or flat file errors and must be immediately repaired by the Medicare contractor and retransmitted to the COBC. In addition, after translating claims into the ANSI X12-N 837 format, the COBC may detect HIPAA ("222") errors. COBA trading partners may also find problems with the claims and dispute the claims back to the COBC as "333" errors. If so, the COBC includes both categories of errors on the DER transmitted to the MAC or DMAC. The MAC or DMAC, in turn, notifies the provider that these claims will not be crossed over. The provider then becomes responsible for collaborating with the supplemental payer to obtain payment.

The crossover process is a service provided by CMS to supplemental payers. In cases where claims have errors and cannot pass HIPAA compliance validation, the supplemental payer must work with the provider for payment reconciliation, which is outside of this process.

Impact:

- The paid claims file (837 flat file) received by the COBC from the claims processing systems will be updated to accommodate ICD-10 codes. The COBC will have to update its Ingenix/Claredi HIPAA translator product to handle the new file format. This impact is ***minor*****.** The claims data are provided in a flat file, limiting the scope of any changes required by the COBC to the Ingenix/Claredi HIPAA translator. In addition, the COBC will have to make changes to its processes and systems to accommodate the new HIPAA 5010 standard, which will precede the transition to ICD-10. The HIPAA 5010 format provides additional spacing for the ICD-10 codes.

9. The COBC, using its Ingenix/Claredi HIPAA translator product, maps the claim to the HIPAA X12 837 format and then validates the claims for HIPAA compliance. Non-standard claims are logged in the DER and reconciled by the MAC, provider and supplemental payer.

   There is the possibility for invalid ICD codes to exist in claims even after claims processing and adjudication and those claims with invalid codes may be found by the COBC. There are multiple front-end systems receiving Medicare claims. Each front-end system has different variations of edits for validating claims and ICD codes, following the basic guidelines from CMS. Additionally, the processing for handling paper claims does not require all ICD codes in a claim to be validated. Only diagnosis codes pointed to at the claim service line level are currently validated. During the translation and validation performed by the COBC, the COBC may find invalid ICD codes in the claims. The COBC will reject those claims for crossover. The COBC will log these errors in the DER to be sent to the MACs or DMAC.

   Impact:

   - The COBC will have to make changes to its processes and systems to accommodate the new HIPAA 5010 standard, which will precede the transition to ICD-10. The

HIPAA 5010 format provides additional spacing for the ICD-10 codes. This initial work will lessen the impact of the transition to ICD-10. COBC's Ingenix/Claredi HIPAA translator product must accommodate ICD-10 codes for mapping claims in the X12 837 format and be able to validate the ICD-10 codes, while maintaining the ability to accommodate ICD-9 codes. This impact is ***minor.*** The COBC relies on a commercial application for the Ingenix/Claredi HIPAA translator product. The COBC will not have the responsibility to make programming changes to the translator and will rely on the commercial vendor. Their responsibilities will be focused on any configuration changes and validation of the application changes for the ICD-10 codes.

10. The COBC, using the Ingenix/Claredi HIPAA translator, aggregates and sends claims in the X12 837 file to the appropriate payer. This file contains ICD codes. Supplemental payers receive and validate the X12 837 file. For claims failing the payer's edits, payers can decline the claim and will notify the COBC. The COBC will log declined claims in the Detailed Error Report (DER). The DER is sent to the MAC or DME MAC processing the claim. The MAC or DMAC, in turn, notifies the provider/supplier that the affected claim will not be crossed over.

    Payers also have the ability to file complaints via the CMS HIPAA Issues Log. CMS and the supplemental payers utilize different applications and rules for validating the X12 837 files for HIPAA compliance. When the editing standards differ, payers can submit issues and CMS uses the HIPAA Issues Log to track and manage those issues. These issues may result in changes to the HIPAA validations occurring during the crossover process or in the Medicare contractors' front-end systems and internal claims processing systems. OFM/FSG works with OIS/Division of Medicare Billing Procedures (DMBP) to review these issues and determine the resolution.

    Impact:

    - The COBC contractor will need to make changes to its processes and system to accommodate the new HIPAA 5010 standard, which will precede the transition to ICD-10. The HIPAA 5010 format provides additional spacing for the ICD-10 codes. This initial work will lessen the impact of the transition to ICD-10. The Ingenix/Claredi HIPAA translator will need to be able to accommodate ICD-10 codes for sending claims in the X12 837 format and be able to validate the ICD-10 codes, while maintaining the ability to handle ICD-9 codes. This impact is ***minor.*** The COBC relies on a commercial application for the Ingenix/Claredi HIPAA translator. The COBC relies on a commercial application for the Ingenix/Claredi HIPAA translator. The COBC will not have the responsibility to make programming changes to the translator and will rely on the commercial vendor to do so. The COBC's responsibilities will be focused on any configuration changes and validation of the application changes for the ICD-10 codes.

11. Once the Supplemental payer has accepted the claim, payment is made to the provider. This portion of the process is external to CMS and its supporting contractors. The supplemental payer will determine the appropriate remittance to the provider and send

the remittance advice. Payers may use the X12 835 format to electronically pay the provider. The X12 835 format is the Claim Payment & Remittance Advice transaction mandated by the HIPAA standard.

Impact: No Impact.

- **This portion of the process exists outside of CMS and its contractors.**

Process Risk Assessment

The COBA process is a service provided by CMS to supplemental payers to facilitate payment of claims where beneficiaries have insurance coverage, in addition to Medicare. If changes to the COBA supporting processes and systems are not properly implemented to accommodate ICD-10 codes and associated impacts, the risk to the COBA process will be the inability to properly handle claims with ICD-10 codes. This would result in an inaccurate crossover claim being sent or no crossover claim being sent to a supplemental payer.

This risk is ***minor***[51]**.** In cases where claims do not pass edits performed by the COBC, the claim is not sent to the supplemental payer by the COBA process. The supplemental payers and providers have procedures in place to exchange claim information and reach payment reconciliation outside of this COBA process.

Processes with which COBC are involved are on the back end of the Part A and Part B claims processing process, post Medicare claim adjudication. At this point, CMS has fully adjudicated the claim. Any issues or errors occurring during the COBA process will not result in changes to CMS' adjudication.

In addition, the HIPAA 5010 implementation is planned to occur prior to the implementation of ICD-10. The HIPAA 5010 standard will accommodate the expanded ICD-10 code format. The system supporting the COBA process, Ingenix/Claredi HIPAA translator, will have to be updated to send the modified file format to payers, prior to ICD-10 transition. The COBC relies on a commercial application for the Ingenix/Claredi HIPAA translator. The COBC will not have the responsibility to make programming changes to the translator for HIPAA 5010 or for the ICD-10 transition and will rely on the commercial vendor to do so. The COBC's responsibilities will be focused on configuration changes and validation of the application changes for the ICD-10 codes.

The risks to CWF, FISS, MCS and VMS are discussed in the Part A and Part B claims processing process summary report.

[51] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project

Medicare Integrity Operations Impact Rank: Medium

Table 25. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Centers for **Medicare Integrity Operations Process Rank: Medium**[52] **(Orange Level)**	Office of Financial Management (OFM) / Program Integrity Group (PIG) / Division of Benefit Integrity Management Operations (DBIMO): (Orange Level)	Office of Financial Management (OFM) / Program Integrity Group (PIG) / Division of Medical Review and Education (DMR): (Orange Level)	Office of Financial Management (OFM) / Program Integrity Group (PIG) / Division of Analysis and Evaluation (DAE): (Orange Level)

Process Overview

There are nine processes associated with Medicare Integrity Operations:

- Oversee Identification of Improper Payment for Medicaid Payment Error Rate Measurement (PERM) Process
- Identify and Investigate Allegations of Fraud
- Handle Requests for Medical Review from Law Enforcement Agency
- Handle Requests for Information
- Medi Medi Integrity Process
- Oversee Identification of Improper Payments for Medicare Comprehensive Error Rate Testing (CERT) Process
- Perform Data Analysis for Medical Review
- Perform Post-Payment Medical Review
- Perform Pre-Payment Medical Review

Medicaid Payment Error Rate Measurement (PERM)

The Improper Payment Information Act (IPIA) of 2002 mandates Federal agencies estimate the amount of improper payments and report those estimates to Congress. The Centers for Medicare & Medicaid Services (CMS) in compliance with the IPIA implemented the PERM program to measure improper payments in the Medicaid program and State's Children Health Insurance Program (SCHIP). The PERM process estimates payment error rates for the fee-for-service and managed care components of both the Medicaid program and the SCHIP program.

[52] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

A seventeen state rotation cycle was created with each state participating in the PERM process once every three years. The PERM process uses a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collections and medical and data processing reviews of selected state Medicaid and SCHIP fee-for-service and managed care claims. The Division of Analysis and Evaluation (DAE) within the Program Integrity Group (PIG) of the Office of Financial Management (OFM) is responsible for the oversight of the PERM program. The State Medicaid Error Rate Findings (SMERF) database is the system the OFM/PIG/DAE and the contractors utilize for the PERM process.

Impact

One impact for the ICD-10 transition to the PERM process will be the reprogramming of the SMERF database. The SMERF has pre-determined field lengths for ICD-9 code storage and will need to be modified to accept the increased field length associated with ICD-10 codes. Additionally, since states may not transition to ICD-10 at the same time, the SMERF will need to be modified to allow the storage of both ICD-9 and ICD-10 codes. There will also be an impact to the data the contractors utilize to determine improper payment. The Medical Review Contractors may receive PERM data containing ICD-9 codes from some states and ICD-10 codes from other states resulting in the need for the contractors to have mappings between the two coding systems available. The contractors will need in-depth ICD-10 education and training in order to accurately review claims and medical records after the transition to ICD-10. As it takes three years to review all states, a rolling national average is calculated for comparison of all states. With the transition to ICD-10 there will be a period of time that data used to compile this national average will contain both ICD-9 and ICD-10 codes. Mappings between the two coding systems will need to be utilized accurately in order to correctly calculate the rolling national average. The impact is ***medium***.

Risk Assessment

The risk to OFM/PIG/DAE for the PERM processes is ***medium***[53]. OFM/PIG/DAE is required by the IPIA statute to administer the improper payment programs for Medicaid. If the transition to ICD-10 does not go smoothly, DAE may not be able to meet their mandate and be in violation of the statute. The PERM contractors perform data analysis and trending, resulting in reports that contain improper payment error rates based on ICD-9 data. Data for this program is tracked yearly and across years to analyze trends in the improper payment error rates. Crosswalks will be utilized, but the data mappings between ICD-9 and ICD-10 is not a one-to-one match. Ineffective mapping could result in inaccurate trending of payment error rates. The PERM contractors will require in-depth ICD-10 training to accurately perform data analysis and trending. Additionally, OFM/PIG/DAE relies extensively on ICD-9 codes supplied by the individual state's systems to identify and measure improper payments. If any of these systems were to be updated with ICD-10 codes either inaccurately or in an untimely fashion, OFM/PIG/DAE may not be able to identify improper payments. Annually the PERM findings are published in the Health and Human Services' (HHS) Performance and Accountability Report (PAR). If inaccuracies in improper payment errors result from the transition to ICD-10, the PAR which is published on HHS' website will be inaccurate.

[53] A Medium or Orange Level Process may be interrupted without complete stoppage

Program Safeguard Contractor Processes

The Medicare Fraud Program is an important part of the Medicare Integrity Program and Program Safeguard Contractors/Zoned Integrity Contractors (PSCs/ZPICs) are utilized to perform the requirements of this program. ZPICs eventually will replace PSCs to better align with MAC service areas. The Division of Benefit Integrity Management Operations (DBIMO) within the OFM/PIG has oversight responsibility of the PSCs/ZPICs. Of the various processes that the PSCs perform, four processes were identified that utilized ICD-9 codes:

- Identify and Investigate Allegations of Fraud process
- Medi Medi Integrity process
- Handle Requests for Medical Review for Law Enforcement Agency process
- Handle Request for Information process

The identification of potential Medicare fraud (Identify and Investigate Allegations of Fraud process) is achieved either through reactive and proactive identification of potential fraud. Reactive identification relies on complaints from individuals who suspect fraud. Proactive identification is performed by reviewing provider's claims and associated data to identify patterns, trends or aberrances in billing patterns. Once identified, the Program Safeguard Contractor Business Investigation (PSC/ZPIC BI) unit will perform further analysis on the potential fraud. The PSCs/ZPICs BI unit's findings can result in various courses of action such as suspension of payments to the provider, revocation of a provider's privileges, collection of overpayments, continued monitoring of the provider, and referral to the Office of the Inspector General (OIG). The PSCs/ZPICs receive data from numerous CMS sources to identify and investigate potential fraud. The CMS data sources include a TAP file from the National Claims History (NCH), data feeds from the shared systems, and feeds from other CMS summary and detailed data systems. These various data sources are loaded into the PSCs/ZPICs Data Warehouses. In addition, OFM/PIG/DBIMO is the business owner of a system which tracks the progress of a case through closure.

The Medi Medi Integrity process is used to identify potential fraud crossing between Medicare and Medicaid. The Medi Medi (MM) PSCs/ZPICs review and analyze claims data from both the Medicare and Medicaid programs to detect patterns than may not be evident when billing for either program are viewed in isolation. The MM PSC/ZPIC Data Warehouse receives and stores data feeds from NCH and the CMS shared systems in addition to feeds from the states Medicaid Management Information System (MMIS).

The Handle Requests for Medical Review from Law Enforcement Agency process involves the PSC/ZPIC BI receiving requests for medical review from law enforcement agencies. Law enforcement agencies who are building cases against providers will request the PSC/ZPIC BI to perform analysis of claims data looking for over billing and potential fraudulent activities. The systems and data analysis performed are the same as outlined in the Identify and Investigate Allegations of Fraud process.

The Handle Requests for Information process involves the PSC/ZPIC receiving requests for information from stakeholders including authorized data users, the Office of the Inspector General, and the Department of Justice. These requests can either be for national or local data. National data requests are forwarded to the Office of Information Services (OIS) within CMS. Local data requests will be processed by the PSC/ZPIC BI unit after confirming that the request meets the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. The data used to answer the information request is supplied to the PSC/ZPIC BI by the MAC and could contain ICD-9 codes.

Impact

The primary impacts for the ICD-10 implementation to the Identify and Investigate Allegations of Fraud process are reprogramming and modifying the PSC/ZPIC Data Warehouse and the system used to track cases through closure and the analysis and trending of data to identify potential fraud. The PSC/ZPIC Data Warehouses and the case tracking system will need to be modified to accept and store ICD-10 codes. PSC/ZPIC staff including data analysts, nurses and investigators will require in-depth ICD-10 training in order to continue the analysis and investigation required to identify potential fraud. Trending of data and comparative studies will require the accurate use of crosswalks/mappings. The impact is currently assessed at ***medium*****,** but additional investigation is required to confirm a higher impact.

The primary impacts for the ICD-10 implementation to the Medi Medi Integrity process will be to the MM PSC/ZPIC Data Warehouse. With the transition to ICD-10, the MM PSC/ZPIC Data Warehouse will require modification to accept and store ICD-10 codes and algorithms will need to be updated with ICD-10 codes. The data analysis performed by the MM PSCs/ZPICs will also be impacted by the transition to ICD-10. If the states transition to ICD-10 at different times, the data used to perform the analysis will contain ICD-10 data from Medicare and ICD-9 from Medicaid. In this instance, the MM PSC/ZPIC will be required to use the existing mapping to complete their analysis. The MM PSC/ZPIC will require in-depth ICD-10 training in order to accurately perform their analysis as the relationship between ICD-9 and ICD-10 is not a one-to-one relationship. The complexity resulting from the uniqueness of the data of each state and status of implementing ICD-10 that may result in the need to operate parallel systems when more than one state is included in a PSC/ZPIC and the problems cited above for Identify and Investigate Allegations of Fraud process suggest that further assessment of this process is warranted. The impact is currently assessed at ***medium*****,** but additional investigation is required to confirm a higher impact.

The impact to the Handle Requests for Information process with the transition to ICD-10 is that the data supplied to the PSC/ZPIC BI could be inaccurate or not provided in a timely fashion. Benefits have been leveraged from changes implemented for the Identify and Investigate Allegations of Fraud process and the Medi Medi processes. The impact is ***modest***.

Risk Assessment

The risk to OFM/PIG/DBIMO for Medicare Fraud Program is ***medium***. The PSCs/ZPICs rely on data from numerous CMS systems such as NCH and the shared systems to perform their data analysis. If any of these systems were to be updated with ICD-10 codes either inaccurately or in an untimely fashion, OFM/PIG/DBIMO may not be able to accurately

identify trends, patterns or aberrances for the identification of potential fraud. Even with timely updating of NCH and shared systems, there is a risk that the PSCs may not be able to update their databases timely and may not be able to receive and/or load the updated data from NCH and the shared systems into their databases. Further, the identification of trends and patterns requires the review of data over a period of time. The PSC/ZPIC will utilize crosswalks, but the data mapping between ICD-9 and ICD-10 is not a one-to-one match. Mappings between the two coding systems can be one-to-one, many-to-many or may not map at all. The availability of comprehensive crosswalks is critical; in their absence, PSCs/ZPICs will be required to expend significant effort to address any gaps in the crosswalks, thus delaying use of existing algorithms used to detect fraud, abuse, and waste. Further, implementation and interpretation of the maps will require personnel with a skilled knowledge of ICD-9 and ICD-10. Investigators, analysts, and nurses will need to have a complete understating of ICD-10 codes to identify fraudulent coding practices including up-coding. The inability to accurately identify potential fraud could result in the potential of lost Medicare Trust Fund monies. The Medi Medi program reviews both Medicare and Medicaid data. If the states do not transition to ICD-10 in the same time frame that Medicare does the data used to perform the Medi Medi analysis will contain ICD-10 data form Medicare and ICD-9 data from Medicaid. Again, crosswalks and mappings would be required to accurately determine the existence of any potential fraud.

Comprehensive Error Rate Testing (CERT)

CMS in compliance with the IPIA implemented the CERT program to measure improper payments in the Medicare program. The CERT process estimates payment error rates and monitors the accuracy of Medicare fee-for-service payments. The CERT process uses a national contracting strategy consisting of three contractors to perform statistical calculations, detail of claims collection and medical reviews of selected Medicare fee-for-service claims. The OFM/PIG/DAE is responsible for the oversight of the CERT program. The CERT Tracking and Reporting Database and System (CTRDS), a review and tracking database, is the system OFM/PIG/DAE and the contractors utilize for the CERT process. Additionally, a Claims Status Website is utilized by the CERT contractors to post identified payment errors. This website is also utilized to track the feedback and dispute processes. A mid year and annual Improper Medicare Fee for Service Payment Report (IFMP) are published on the CMS website.

Impact

The primary impacts for the ICD-10 transition to the CERT process will be the reprogramming of the CTRDS and Claims Status Website and the impact to the data the contractors utilize to determine improper payments. The CTRDS has pre-determined field lengths for ICD-9 code storage and will need to be modified to accept the increased field length associated with ICD-10 codes. The payment error findings posted to the Claims Status Website contain ICD-9 codes. Additionally, the MAC when disagreeing or disputing the findings for an acute care hospital claim is able to dispute the ICD-9 code that was determined to be in error. The Claims

Status Website will need to be modified to accommodate accepting ICD-10 codes. Additionally, the CERT contractors will need in-depth ICD-10 education and training in order to accurately review claims and medical records after the transition to ICD-10. With the transition to ICD-10, the annual IFMP for the year of implementation will contain payment error rates resulting from the review of claims with both ICD-9 and ICD-10 codes. Accurate mapping between the two coding systems will be required for correctly calculated payment error rates. The impact is ***medium***.

Risk Assessment

The risk to OFM/PIG/DAE for the CERT processes is ***medium***[54]. OFM/PIG/DAE is required by the IPIA statute to administer the improper payment programs for Medicare. If the transition to ICD-10 does not go smoothly, DAE may not be able to meet their mandate and be in violation of the statute. The CERT contractors perform data analysis and trending, resulting in reports that contain improper payment error rates based on ICD-9 data. Data for this program is tracked yearly and across years to analyze trends in the improper payment error rates. Crosswalks will be utilized, but the data mappings between ICD-9 and ICD-10 is not a one-to-one match. Ineffective mapping could result in inaccurate trending of payment error rates. The CERT contractors will require in-depth ICD-10 training to accurately perform data analysis and trending. Additionally, OFM/PIG/DAE relies extensively on ICD-9 codes supplied by the CMS shared systems to identify and measure improper payments. If any of these systems were to be updated with ICD-10 codes either inaccurately or in an untimely fashion, OFM/PIG/DAE may not be able to identify improper payments. Annually the CERT findings are published in the Health and Human Services' (HHS) Performance and Accountability Report (PAR). If inaccuracies in improper payment errors result from the transition to ICD-10, the PAR which is published on HHS' website will be inaccurate.

Medical Review Contractor Processes

The Medical Review Program is an important part of the Medicare Integrity Program and Medical Review (MR) staff are utilized to perform the requirements of this program. The Division of Medical Review and Education (DMR) within OFM/PIG has oversight responsibility of the MR Staff. The MR Staff have three processes that utilize ICD-9 codes:

- Perform Data Analysis for Medical Review
- Perform Post-Payment Medical Review
- Perform Pre-Payment Medical Review

The Perform Data Analysis for Medical Review process involves the MR staff reviewing claims and other pertinent information to determine whether services provided are medically reasonable and necessary. Numerous CMS data sources are provided to the MR staff including the shared systems, NCH, Health Care Information System (HCIS), Part B Summary System

[54] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project

(BESS), Services Tracking, Analysis & Reporting System (STARS) and CERT reports. These various data sources are loaded into the MR staff's internal data warehouse. Through the analysis of data and probe reviews, the MR staff identify claims subjected to pre or post payment review.

The Perform Post-Payment Medical Review process begins with the MR staff selecting the claims for the post payment review. Once identified, the MR staff with review the claim and additional information to identify those claims that have either been over or under paid.

The Perform Pre-Payment Medical Review process begins with MR staff determining and/or implementing edits into the claims processing systems for review. These edits with either flag claims for routine review or suspend claims for a complex review. Additionally edits can be set to auto deny claims. Claims identified for routine review will be reviewed by the MR staff and a determination of approval or partial/full denial of the claims will be made. Claims flagged for complex review will require the MR staff to review both the claim and the medical record for determination of approval or partial/full denial of the claim. Once the MR staff has completed their review, the claim will continue to follow the claims processing flow.

Impact

The primary impacts for the ICD-10 transition to the Medical Review processes will be the reprogramming of the MR staff Data Warehouse and the impact to the data the MR staff utilize to perform medical review. The OFM/PIG/DMR will have oversight responsibility in assuring that the Data Warehouses are reprogrammed to receive, accept and store ICD-10 codes. The MR staff will need in-depth ICD-10 education and training in order to accurately review claims and medical records after the transition to ICD-10. The impact is ***medium***.

Risk Assessment

The risk to OFM/PIG/DMR is ***medium***. The MR staff rely on numerous CMS systems such as NCH and the shared systems to perform their data analysis. If any of these systems were to be updated with ICD-10 codes either inaccurately or in an untimely fashion, OFM/PIG/DMR's ability to review claims for compliance with billing and coding guidelines would be affected. MR staff perform analysis of data over time which could be affected with the transition from ICD-9 to ICD-10. The MR staff will utilize crosswalks, but the data mapping between ICD-9 and ICD-10 is not a one-to-one match. Mappings between the two coding systems can be one-to-one, many-to-many or may not map at all. Implementation and interpretation of the maps will require personnel with a skilled knowledge of ICD-9 and ICD-10. MR staff will need to have a complete understating of ICD-10 codes to identify claims that are noncompliant with billing and coding guidelines. The inability to accurately identify inaccurate claims could result in the potential of lost Medicare Trust Fund monies.

Medicare Secondary Payer Process
Impact Rank: Medium

Table 26. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank Medicare Secondary Payer (MSP) Process: **Medium**[55] **(Orange Level)**	Office of Financial Management (OFM)/Financial Services Group (FSG)/Division of Medicare Debt Management (DMDM): Medium (Orange Level)

Process Overview

Medicare Secondary Payer (MSP) process identifies Medicare beneficiaries with primary insurance coverage carrying Medicare as a secondary payer. The Coordination of Benefits Contractor (COBC) is an authorized contractor of CMS/Office of Financial Management (OFM)/Financial Services Group (FSG)/Division of Medicare Benefit Coordination (DMBC). The COBC collects information on beneficiaries where Group Health Plans (GHP) and Non-Group Health Plans (Non-GHP) are the primary payers to Medicare. GHP coverage involves those beneficiaries that have an employer based insurance plan covering medical care and health services primary to Medicare. Non-GHP coverage involves those beneficiaries with insurance based on an accident which includes Worker's Compensation (WC), liability or Automobile/No-Fault insurance. These insurers pay as the primary insurer for specific injuries due to these types of accidents.

There is also the recovery aspect of the MSP program that focuses on identifying beneficiary' claims which CMS may have erroneously paid as the primary insurer and to recover funds mistakenly paid, or paid conditionally, by CMS.

The Medicare Secondary Process Recovery Contractor (MSPRC) is the national MSP Recovery Contractor as of October 2, 2006. All the functions and workloads related to Medicare Secondary Payer (MSP) post-payment recoveries are the responsibility of the MSPRC with the exception of provider based recoveries.

Group Health Plan

COBC updates the Common Working File (CWF) for beneficiaries with GHP insurance information when Medicare is the secondary payer. COBC provides information on the beneficiary regarding his/her insurer and the dates of coverage. CWF, National Claims History (NCH) and National Medicare Utilization Database (NMUD) are accessed for claims investigations. The MSPRC utilizes the Data Extract System (DESY) to access information from NCH and NMUD. Data utilized by the MSPRC is related to dates of coverage on GHP plans and investigations are focused on dates of service. The reviewed claims contain ICD-9

[55] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project.

data but ICD information is not the focus of the investigations. MSPRC (contracting with OFM/FSG/DMDM) pulls leads from CWF and loads the information into Recovery Management and Accounting System (ReMAS). MSPRC utilizes the lead information to determine what claims records to retrieve from the CMS repositories. The System for MSP Automated Recovery and Tracking (SMART) is utilized by MSPRC to create the account receivable record and a demand letter for repayment. MSPRC sends the letter with paper copies of claims to Employer/Insurer for payment. Examples of GHP types include:

- Working Aged
- End Stage Renal Disease (ESRD)
- Federal, Public Health
- Veteran's Affairs
- Black Lung
- Disabled

Non-Group Health Plan

Non-Group Health Plans insure beneficiaries for specific conditions resulting from accidents or injuries, e.g., WC, Automobile or Liability cases. The COBC collects information on Medicare beneficiaries with Non-GHP coverage from beneficiaries, the states, Worker's Compensation Recovery Contractor (WCRC) or other entities including, but not limited to, liability insurers, auto/no-fault insurers, attorneys, etc. The COBC identifies those beneficiaries with Non-GHP coverage and sends this information to CWF so claims are processed appropriately. The MSPRC also utilizes the beneficiary information in CWF to determine what claims records to retrieve and review from CMS repositories, i.e., CWF, NCH or NMUD. MSPRC is attempting to determine if Medicare paid claims related to the beneficiary's injury are covered by the Non-GHP insurance. Investigations are limited to specific conditions treated and paid through liability insurance, e.g., fractures, injuries related to auto accident. MSPRC sends claims to an application service to group claims into episodes of treatment and translate diagnosis to a smaller set of descriptive categories. Translation provides easier to understand description of diagnosis compared to ICD codes. When conditionally paid claims are discovered, the MSPRC will work with the beneficiary or the beneficiary's attorney to settle the case and collect the repayment. The MARTI system (MSP Automated Recovery and Tracking Initiative) is used by MSPRC to create the accounts receivable record for the repayment. Examples of Non-GHP types include:

- Worker's Compensation
- Automobile/Liability No-Fault
- Liability

For Workers' Compensation, CMS works with the Coordination of Benefits Contractor (COBC) and Workers' Compensation Review Contractor (WCRC) to collect information on beneficiary's injuries, illness and diseases due to a work related incident. The beneficiary, or his professional representative or representative payee, sets aside a certain amount of the WC funds for future medical costs called the Workers' Compensation Medicare Set-Aside

Arrangement (WCMSA). The WCRC reviews the case and makes recommendations as to whether the proposed WCMSA amount is adequate.

The primary impacts for the MSP process are the changes required in ReMAS to accommodate for ICD-10 related changes to CMS repositories and systems, i.e., CWF, NCH, NMUD and DESY. MSPRC and OFM/FSG/DMDM will have to react to any changes made to CMS repositories and DESY to accommodate ICD-10 codes. ReMAS interfaces with these systems to gather claims information. ReMAS interfaces may require updates to coordinate with changes to CMS repositories and DESY. These modifications will require designing, developing and testing. In addition, MSPRC and OFM/FSG/DMDM will have to modify ReMAS to store expanded ICD-10 codes. ReMAS also supports a number of outgoing interfaces that contain ICD, including the Medicare.gov site, an external application for grouping claims called Symmetry and the printing of demands to beneficiaries and attorneys. The inability to collect, store and use claims information will prevent the MSPRC from completing its work and may prevent or delay the identification of conditional payments by CMS.

Related Processes

The MSP Process is connected to Manage CMS System Repositories and their Data Outputs Process.
The MSP Process relies on data from the CMS Repositories (CWF, NCH, NMUD).

Process Description

Group Health Plan Process

1. COBC works to collect information on those beneficiaries that have GHP coverage. Beneficiaries, providers, GHP insurers and employers contact the COBC to notify them of a beneficiary's primary insurance coverage. Employers and insurers may have data sharing agreements in place with the COBC to submit beneficiary MSP information on a quarterly basis. There are ICD codes in the data collected by COBC and sent to CWF so claims are processed correctly.

   Impact:
   - COBC will need to accommodate ICD-10 codes in the information collected on beneficiaries with Medicare as the secondary payer. This impact is ***medium***.

2. COBC daily updates the CWF Medicare Secondary Payer (MSP) auxiliary file, identifying beneficiaries with other primary insurance. COBC provides information on the beneficiary, including his/her insurer, employer information, spousal information, if any, and the dates of MSP coverage. This information is used as leads by the MSPRC to

find Medicare incorrect payments. There are ICD codes in the data provided by COBC and sent to CWF however they are not the focus of this recovery process.

Impact:

- COBC will need to accommodate ICD codes in the transmission of information sent to CWF. This impact is ***minor***[2]**.**

3. MSPRC, contracting with OFM/FSG/DMDM, receives the beneficiary MSP information from CWF and loads the information into ReMAS. ReMAS is owned by OFM/FSG/DMDM and maintained by OFM/Budget and Analysis Group. MSPRC utilizes the beneficiary MSP information as leads to determine what claim records to retrieve from CMS' repositories, CWF, NCH or NMUD. There are ICD codes in this step however they are not the focus of this recovery process.

   Impact:

   - MSPRC and OFM/FSG/DMDM will have to modify ReMAS to store and display expanded ICD-10 codes and maintain the ability to store and display ICD-9-CM codes. This impact is ***medium.*** The inability to store claims information will prevent the MSPRC from completing its work and may prevent or delay the identification of overpayments by CMS.

4. MSPRC using ReMAS retrieves claims information from CMS repositories. NCH and NMUD provide access to claim information. MSPRC utilizes DESY to access data in NCH and NMUD. MSPRC stores the retrieved claims in ReMAS. There are ICD codes in the claims. ReMAS will also retrieve and store beneficiary information (no ICD codes) from Medicare Beneficiary Database (MBD). MBD stores beneficiary demographic data to support the collection and maintenance of Medicare beneficiary information (e.g., enrollment, insurance, premium payments).

   Impact:

   - MSPRC and OFM/FSG/DMDM will have to react to any changes made to CMS repositories and DESY to accommodate ICD-10 codes and maintain the ability to store and display ICD-9-CM codes. ReMAS interfaces with these systems to gather claims information. Those ReMAS interfaces may require updates to coordinate with changes to CMS repositories and DESY. This impact is ***medium.*** These modifications will have to be designed, developed and tested. The inability to collect claims information will prevent the MSPRC from completing its work and may prevent or delay the identification of overpayments by CMS.

5. MSPRC utilizes ReMAS to review claims to determine if CMS paid claims as a primary payer, when it should have paid as the secondary payer. These are cases where the beneficiary had or has another insurer who should have paid as the primary. ReMAS will compare the dates of coverage of the beneficiary's primary insurance provided by

[2] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

Impact:

- MSPRC and OFM/FSG/DMDM will have to modify ReMAS to store and display expanded ICD-10 codes. This impact is ***medium***.

6. MSPRC uses ReMAS to send the cases with claims for repayment to SMART. SMART is an account receivable and case tracking system on claims requiring re-payment. SMART is used and maintained by the MSPRC. The claims for repayment are stored in SMART and will contain ICD codes. In addition, SMART generates demand packages to Insurers/Employers comprised of claim facsimiles and payment summaries which contain ICD codes. The printing contractor receives these demand packages and provides printing services.

   Impact:

   - MSPRC and OFM/FSG/DMDM will have to modify SMART to store expanded ICD-10 codes and modify the demand package generated by SMART to allow for the expanded ICD-10 codes. This impact is ***medium.***
   - The printing contractor, working with OFM/FSG/DMDM may need to modify the demand package printing software to allow for the expanded ICD-10 codes on the claim facsimile and payment summary documents. This impact is ***modest***[56]**.**

7. MSPRC uses SMART to create the account receivables for the cases and to create demand letters for re-payment. MSPRC sends the letter to Employer/Insurer for collection.

   Impact: No Impact

8. Employer/Insurer can:
   - Pay the claims and the MSPRC will close the case.
   - Negotiate payment. The Employer or Insurer will defend their position for non-payment or for a lower payment. These defenses include a review of the ICD codes to determine benefit coverage applicability. MSPRC will review case and settle on new or same amount. Employer/Insurer can then pay the new amount and the MSPRC will close the case.

[56] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

- Not pay claim. The case is sent to Department of Treasury for collection however no ICD data is included.

Impact: No Impact

Non-Group Health Plan Process

1. COBC working with OFM/FSG/DMDM collects information on the beneficiaries with non-GHP insurance where Medicare is the secondary payer. Beneficiaries have Non-GHP insurance for specific conditions or injury (e.g. Worker's Compensation, Auto/No-fault or Liability). This lead information can come in from the beneficiary, the states, the attorneys, the WCRC or other submitters.

   Impact: No Impact

2. For Workers' Compensation cases, COBC sorts and scans all the case documents received in the WCCCS for beneficiary work related injuries, illnesses or diseases. This information can come in from the beneficiary or other submitters. The ICD codes are entered in the diagnosis codes tab in the WCCCS. Listed below is some of the type of information reported to the WCRC:

   - Beneficiary's name
   - Beneficiary's Medicare Health Insurance Claim Number (HICN) or SSN
   - Date of incident
   - Nature of illness/injury
   - ICD 9 codes
   - Name and address of the WC insurance carrier
   - Name and address of the legal representatives
   - Name of insured
   - Policy/claim number

   Impact: No Impact

3. For WCMSA cases, is initially received, scanned and entered by the COBC to create a regular workers' compensation record in CWF. When the COBC completes these activities, the case is systematically assigned to the WCRC. The WCRC reviews the case makes recommendations to determine if the WCMSA proposed amount is adequate. When the WCRC completes its review, the case is submitted to the appropriate RO. The RO assigned to the case is based on the state of residence of the beneficiary. The approval letter is generated when the case is in approved status. An attachment (attestation form) is also generated with the approval letter based upon who will administer the WCMSA. (self-administered, professional administered, or representative payee) After receiving the final settlement agreement, according to applicable State law, the RO enters the final settlement date into the Settlement Date field on the Settlement Detail tab in order to complete the case.

The administrator of the WCMSA funds will be responsible for accounting for the proper exhaustion and use of these funds. (attestation form)

Impact: No Impact

4. COBC provides daily updates to the CWF Medicare Secondary Payer (MSP) auxiliary file, identifying beneficiaries with other primary insurance. COBC will provide beneficiary Non-GHP information, and the diagnosis code(s) relating to that injury. COBC will update CWF records to indicate the specific type of Non-GHP, for example, Worker's Compensation. This information is used as leads by the MSPRC. The COBC will also indicate if the beneficiary has a WCSA in the MSP CWF record.

   Impact:

   - The COBC's update to the CWF for non-GHP claims contains the diagnosis code for beneficiary's injury. The function to update the CWF must be modified to handle expanded field size of ICD-10 codes. This impact is ***medium.*** The COBC and CMS will need to determine what modification existing systems and procedures will be required.

5. MSPRC (contracting with OFM/FSG/DMDM) receives the leads from CWF and loads the information into ReMAS. MSPRC utilizes the lead information to determine what claims records to retrieve from CMS repositories, CWF, NCH or NMUD.

   Impact:

   - The lead information retrieved from CWF will contain expanded ICD-10 codes after the transition to ICD-10 and the MSPRC must be able to retrieve expanded codes, store and display them in ReMAS. This impact is ***medium.***

6. MSPRC retrieves claims information from CMS repositories. Which repository is accessed depends on the dates of coverage in question. CWF (via a Health Insurance Master Record (HIMR) screen scraping process) is used for the most recent claims. NCH and NMUD provide access to older claim information. MSPRC utilizes DESY to access data in NCH and NMUD. MSPRC stores the retrieved claims in ReMAS. There are ICD codes in the claims. ReMAS will also retrieve and store beneficiary information (no ICD codes) from Medicare Beneficiary Database (MBD). MBD stores beneficiary demographic data to support the collection and maintenance of Medicare beneficiary information (e.g., enrollment, insurance, premium payments).

   In addition, MSPRC may use the HIMR screens to view claim information for Non-GHP cases. HIMR is a mainframe application for online verification of beneficiary records and claims history for posted claim records.

Impact:

- MSPRC and OFM/FSG/DMDM will have to react to any changes made to CMS repositories, CWF online interface (HIMR) and DESY to accommodate ICD-10 codes. ReMAS interfaces with these systems to gather claims information. Those ReMAS interfaces may require updates to coordinate with changes to CMS repositories and DESY. This impact is ***medium.*** These modifications will have to be designed, developed and tested. The inability to collect claims information will prevent the MSPRC from completing its work and may prevent or delay the identification of conditional payments by CMS.

- MSPRC and OFM/FSG/DMDM will have to modify ReMAS to store and display expanded ICD-10 codes. This impact is ***medium***. The inability to collect claims information will prevent the MSPRC from completing its work.

7. MSPRC uses ReMAS to send the claims with potential conditional payments for translation and grouping. Ingenix Symmetry is a grouping application service to create English-language translations of the claims information and group claims into episodes of treatment. Symmetry reviews medical claims and specifically the ICD codes to complete the episode-based analysis. This translation and grouping reduces the complexity of the claims and allows MSPRC to determine Medicare conditional payments.

   Symmetry is a third party application providing a service to CMS. CMS is relying on Ingenix to make changes for ICD-10, limiting the impact to CMS processes.

   Impact:

   - MSPRC and OFM/FSG/DMDM will have to modify ReMAS to exchange claims information with ICD codes to Symmetry. This impact is ***modest.*** If there are any modifications to the information provided from Symmetry, ReMAS will have to be able to receive and store the updated format.

8. MSPRC staff reviews the claims, diagnosis code and the episode data provided by Symmetry and may use diagnosis or episode code filters to help identify the conditionally paid claims. The focus of the investigation is to determine if the claim paid for by Medicare, as primary, is related to the injury for which the beneficiary has other primary coverage, for example Auto No-Fault Insurance or Worker's Compensation.

   For claims related to product liability, there may be specific ICD codes associated with a recall and resulting product liability case. MSPRC may have certain ICD-codes associated with product liability.

   Impact:

- MSPRC contracting with OFM/FSG/DMDM may require training to understand the differences between ICD-9 and ICD-10 and the increased specificity of ICD-10 codes. This impact is ***minor.***

- MSPRC will have to associate both ICD-9 and ICD-10 codes with certain product liabilities. The MSPRC may be reviewing claims with either code set, depending on the date of the claim. This impact is ***minor.***

- MSPRC and OFM/FSG/DMDM will have to modify ReMAS diagnosis code filtering functionality to accommodate expanded ICD-10 codes. This impact is ***medium.***

9. When conditional payment is identified, MSPRC works with the beneficiary or attorney to determine settlement for claims. MSPRC uses ReMAS to send the case for repayment to MARTI. The case will have the claim and ICD codes and is stored in MARTI as an accounts receivable record.

   MSPRC also posts information on MyMedicare.gov for beneficiaries to review the details on claims potentially requiring repayment.

   Impact:
   - MSPRC and OFM/FSG/DMDM will have to modify MARTI to store expanded ICD-10 codes. This impact is ***medium.*** The inability to store claims information will prevent the MSPRC from completing its work.
   - The MSPRC and OFM/FSG/DMDM will have to modify the ReMAS interface to MyMedicare.gov to allow for the expanded ICD-10 codes.

10. MSPRC uses ReMAS to create demand letters for re-payment once attorney and MSPRC have agreed on incident related claims. MSPRC sends the letter and copies of the claim(s) to the attorney and/or beneficiary for collection. The printing contractor receives these demand packages and provides printing services.

    Impact:

    - MSPRC and OFM/FSG/DMDM will have to modify the Demand Letters to print expanded ICD-10 codes. This impact is ***modest.***

    - The printing contractor, working with OFM/FSG/DMDM, may need to modify the demand package printing software to allow for the expanded ICD-10 codes on the claim facsimile and payment summary documents. This impact is ***modest.***

11. The Beneficiary can:

    - Pay the claims and the MSPRC will close the case.
    - Not pay claim. The case is sent to Department of Treasury for collection. ICD codes are not used.

Impact: No Impact

Process Risk Assessment

The objective of the MSP process is the identification of beneficiaries' claims which CMS may have erroneously paid, or paid conditionally, as the primary insurer and to recover the funds paid by CMS. The systems supporting this process, ReMAS, MARTI and SMART, exchange and store ICD codes and will require modification to accommodate the expanded ICD-10 codes. In addition, ReMAS has inbound interfaces with CWF and DESY to obtain claims information. ReMAS interfaces will have to accommodate changes to CWF and DESY, as these systems implement ICD-10 specific changes. Outbound ReMAS interfaces for MyMedicare.gov, Symmetry and the printing contractor will also need to accommodate the expanded ICD-10 codes. The COBC, also, provides data with ICD codes to CWF to track beneficiary diagnosis. The COBC will have to accommodate ICD-10 codes in this data exchange. If the impacts of the ICD-10 transition are not properly managed, MSP activities may be interrupted. The inability to process and store claims information would prevent the MSPRC from completing its work and may prevent or delay the identification of overpayments by CMS. If the COBC cannot provide the lead information for beneficiaries with other insurance, MSPRC will have limited information to direct their investigations.

As this is a post-payment activity, there is no risk to claims processing and payment. However, limiting the investigation of mistakenly paid claims may result in lost revenue. Negative impacts from the ICD-10 transition will have a larger impact on the investigations of Non-GHP claims, compared to GHP, since ICD codes are essential on Non-GHP cases. This risk is ***medium***[57]***.***

[57] A Medium or Orange Level Process has the potential for noticeable cost (and/or schedule) increases to the project

Conduct Research Process
Impact Rank: Modest

Table 27. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Process Rank MODEST[58] (Yellow Level)	Office of Research, Development and Information (ORDI)/Information Management Group (IMG)/Division of Survey Management and Data Release (SMDR) (Yellow Level)	Office of Research, Development, and Information (ORDI) / Information and Methods Group (IMG) / Division of Information Development and Analysis (DIDA) (Yellow Level)

Process Overview

The Conduct Research Process includes both collection and dissemination of Medicare and Medicaid data for research projects and for inclusion in Center for Medicare and Medicaid Services' publications. This process provides detailed information on how the transition to ICD-10 codes will impact the processes and systems supporting the Chronic Condition Data Warehouse (CCW) and the Medicare and Medicaid *Statistical Supplement*. The CCW is a data warehouse providing researchers access to CMS data on chronically ill Medicare beneficiaries and the Medicare and Medicaid *Statistical Supplement* is an annual publication on health care finance information. The following is a description of both research entities representing CMS research collection and publications.

Collect and Deliver Chronic Condition Data

The Chronic Condition Data Warehouse (CCW) was created in response to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 legislation requiring a plan to "improve the quality of care and reduce the cost of care for chronically ill Medicare beneficiaries". CCW is a research database assembling information at the beneficiary level from a variety of administrative, clinical, and survey data. The CCW data include claims, enrollment, and assessment data and can be linked by beneficiary across years and files. CCW has claims for a 5% for 1999 through 2004 and all claims for beneficiaries (except Part D) 2005 onward. CCW data files can be extracted for a set of 21 predefined chronic health conditions. CCW data is utilized internally by CMS and is available to external researchers to facilitate chronic care related research projects. The Office of Research, Development and Information (ORDI)/Information Management Group (IMG)/Division of Survey Management and Data Release (SMDR) is the owner of the CCW.

Functions of CCW include ad hoc analysis and delivery of raw data to researchers including raw claim information and assessment data. In addition, program statistics are generated for research purposes. Complex algorithms are utilized to facilitate raw data analysis which will require revisions to accommodate the ICD-10 classification system. Expanded codes and the

[58] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

corresponding specificity in ICD-10 will allow for in depth analysis of condition outcomes and associated costs related to specific diagnoses.

The data sources for the CCW include National Claims History (NCH) for Fee-For-Service claim data, Quality Improvement Evaluation System (QIES) for assessment data and Enrollment Database (EDB) for beneficiary data, as well as, additional sources listed in the Detail Process Section.

The primary impacts for the ICD-10 transition for the CCW relates to the ICD data included in claims, enrollment, and assessment data and the linkage by beneficiary data across years and files. Although a crosswalk between ICD-9-CM and ICD-10-CM exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Research for particular conditions will require additional effort to ensure all parameters for research projects are fulfilled and in some cases may not be possible. In addition, complex algorithms utilized in assigning beneficiaries to one of the 21 clinically-defined chronic or high volume conditions as well as addressing ad hoc analysis will require updating to accommodate the specificity and complexity of the ICD-10 coding classification system. The algorithms updating the pre-defined conditions and expanded additional conditions will need to be vetted with clinicians and academicians for assuring their integrity under the new coding system and determining the degree of continuity with the old coding system.

Collect and Publish Medicare and Medicaid Statistical Supplement:

Medicare and Medicaid *Statistical Supplement* includes charts and tables showing health expenditures for the entire U.S. population, characteristics of the covered populations, use of services, and expenditures under these programs. Office of Research, Development, and Information (ORDI) / Information and Methods Group (IMG) / Division of Information Development and Analysis (DIDA) produces the data for this annual supplement. ORDI/IMG/Division of Research and Information Dissemination (DRID) publishes the annual supplement. It is one of the most comprehensive sources of information available on health care finance in the U.S. The charts and tables are utilized by internal CMS as well as external researchers for a variety of research projects and publications. The tables span multiple years with trended data. ICD-9 level data is utilized in development of trending tables for certain Principal Diagnosis (PDx), ICD-9-CM Principal Procedure, and ICD-9-CM-based Diagnosis Related Groups (DRG) over a period of several years (Note: Medicare-Severity DRGs will be utilized in the 2007 *Statistical Supplement*).

Medicare Provider Analysis and Review (MEDPAR), Standard Analytic Files (SAFs), Catastrophic File System and Annual Person Summary System are the source systems for the supplement's tables. These systems subsequently feed the Table Generation System along with the enrollment data to actually generate the tables. All the systems contain ICD coded data and will require updating to accommodate the expanded ICD-10 codes.

The primary impact to the process of Collect and Publish Medicare and Medicaid *Statistical Supplement* is trending of data over multiple years. The trending will require complex data

analysis and programming to accommodate both ICD-9-CM and ICD-10 coding classification systems. Data analysis is performed on a calendar year. As the implementation of ICD-10 is expected to be accomplished on a fiscal year basis, nine months of data will be in the ICD-9-CM classification and 3 months of that year will be in the ICD-10 classification. Mapping is available to reconcile ICD-9 and ICD-10 diagnoses codes to populate the tables in the supplement. Future consideration for table modifications are made possible due to the increased specificity of ICD-10 allowing data to enhance CMS and external researchers to study disease outcomes and costs related to particular disease processes.

Currently, the Medicaid data included in the *Health Care Financing Review, Annual Statistical Supplement* are not reported by ICD9 codes. However, reporting by ICD9 codes for Medicaid is envisioned for the future, either for dual Medicaid/Medicare enrollees through a link with the Chronic Condition Warehouse or for all Medicaid enrollees (including non-duals). No data sources (systems) related to Medicaid Statistical tables were discussed as ICD data is not currently utilized for development of these tables.

Related Processes

Preceding the Collect and Deliver Chronic Condition Data process is the Manage CMS System Repositories and their Data Outputs process, which documents the NCH and the NCH TAP Files. The NCH TAP file data is one of the main inputs to the CCW. In addition, the Develop and Utilize Assessment Tools process precedes the Collect and Deliver Chronic Condition Data process. Develop and Utilize Assessment Tools process documents the population of assessment data in Quality Improvement Evaluation System (QIES), which stores data used in the creation of the CCW.

Preceding the Collect and Publish Medicare Medicaid ***Statistical Supplement*** Process is the Manage CMS System Repositories and their Data Outputs process, which documents the MEDPAR file and Standard Analytical File (SAF). MEDPAR and SAF are utilized in the creation of the Statistical Supplement.

Process Description

Collect and Deliver Chronic Condition Data Process

1. CMS/Office of Research, Development and Information (ORDI)/Information Management Group (IMG)/Division of Survey Management and Data Release (SMDR) collaborates with the CCW contractor (currently Iowa Foundation for Medical Care (CCW contractor)) to determine the correct parameters to populate the Chronic Condition Data Warehouse (CCW). The parameters will contain ICD codes. CCW contractor has data use agreements in place to access and use data from CMS repositories. Data in the CCW is updated on a monthly basis.

Impacts

- ORDI/IMG/SMDR and CCW contractor will need to determine how to update parameters and queries utilized to build the CCW to account for ICD-10 codes. Although a crosswalk between ICD-9-CM and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Research for particular conditions will require additional effort to ensure all parameters for research projects are fulfilled and in some cases may not be possible. Determining the parameter changes required will provide input for the programming used to create the CCW. Researchers look at data on a calendar basis and the conversion to ICD-10 is planned to start at the beginning of a fiscal year (October 1). This will cause data for one year to be collected in ICD-9 format for 9 months and ICD-10 format for 3 months. This will require a crosswalk to create a uniform data set. This impact is ***modest***. Design and development work will be required to determine how to collect data with two different coding classifications.
- ORDI/IMG/SMDR staff will require training to understand the differences between ICD-9 and ICD-10 codes to properly plan for any updates to parameters and queries to populate the CCW. This impact is ***minor***[59].

2. CCW contractor gathers data for ORDI from multiple CMS data sources for the CCW. CCW contractor has data use agreements in place to access and utilize data from CMS repositories and systems.

   The following data is currently available in the CCW
   - Fee for Service (FFS) Claims data (including DMERC) from National Claims History (NCH) (TAP files) from 2005 to present and Standard Analytical Files (SAF) and Data Extract System (DESY) DESY from 1999 to 2004. This data does contain ICD codes. The FFS Claims data consists of institutional claims for hospital, outpatient, skilled nursing facility, hospice, and home health agency settings. FFS claims data, also, consists of non-institutional claims for Carriers (physician/supplier) and Durable Medical Equipment Regional Carriers (DMERC).
   - Skilled Nursing Facility (SNF) data from Quality Improvement Evaluation System (QIES). This data does contain ICD codes. SNF data is assessment data from nursing facilities (Minimum Data Set (MDS)).
   - Home Health Agency data from QIES. This data does contain ICD codes. Home Health Agency data is assessment data from home health agencies (Outcome and Assessment Information Set (OASIS))
   - Inpatient Rehabilitation Facility (IRF) data is from QIES. This data does contain ICD codes. IRF data is assessment data from inpatient rehabilitation facilities (Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)).
   - Swing Bed Assessment data is from QIES. This data does contain ICD codes. Swing Bed data is assessment data from Swing Bed facilities (Swing Bed Minimum Data Set).

[59] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

- Beneficiary Summary File is built from Enrollment Database (EDB) and Denominator File. It does contain ICD codes. Beneficiary Summary File is the summary of beneficiary demographic information for beneficiaries included in the requested data files.

The following are data planned for future inclusion into the CCW:

- Medicare Part D Enrollment Data from Management Information Integrated Repository (MIIR). This enrollment data does not contain ICD Codes
- Prescription Drug Events (PDEs) from Drug Data Processing System (DDPS). This PDE data does not contain ICD Codes
- Medicaid Claims, Eligibility and Utilization data from Medicaid Analytical Extract (MAX). This Medicaid data does contain ICD codes. The Medicaid data provides additional information of dual eligibles not currently available in CCW.

Impacts

- CCW will require updating to accommodate and store the expansion of ICD-10 coded data from its multiple data sources. This impact is ***modest.*** The CCW relies on data from many sources and those sources with ICD coded data will be modified with the transition to ICD-10. CCW will need to account for those changes.

3. CCW contractor will run their claims-based algorithms to build/update Summary Statistics and CCW Tables. Only the algorithm to build the Chronic Condition Statistics uses ICD Codes.

Outputs from this step are loaded into the CCW.

- Claim Level, Assessment Level and Enrollment Data (raw data). These files are available to respond to chronic care research questions and for future analysis. This data will have ICD Codes.
- Beneficiary Level Analytical Files.
    - CCW Beneficiary Demographics - Medicare Beneficiary Counts for 2000-2006
    - CCW Chronic Condition Statistics - Medicare Beneficiary Counts for Chronic Conditions for 2000-2006
    - CCW Use of Medicare Services
        - Number of Medicare Claims by Claim Type for 2000-2006
        - Number of Medicare Claims by Claim Type and Chronic Condition for 2006
    - CCW Cost of Medicare services – under development
    - Beneficiaries with Nursing Home or Home Health Assessment - Number of Medicare Beneficiaries by Chronic Condition and Assessment Type for 2000-2006

Impacts

- To create the outputs to populate the CCW, the existing algorithms will need to be updated to accommodate changes to parameters and queries based on the mappings of ICD-9 to ICD-10. Algorithms will require rebuilding and vetting with clinicians and academicians. These updates will rely on sufficient planning and once completed, proper testing to confirm data quality. ORDI/IMG contracts to CCW contractor to maintain the CCW and will work to manage any algorithm programming changes. This impact will be modest*. Some of the algorithms utilized to create the CCW program statistics have a "look-back" function to review a beneficiary's claim history for a previous diagnosis of a chronic condition. The diagnosis of the chronic condition would only occur once. However, other diagnoses will occur continually and need to be linked to the original diagnosis. This "look back" function is existing functionality requiring updates to accommodate both ICD-9 and ICD-10 codes.

- Once the updated data is loaded, the raw data and program statistics are available for researchers, both internal and external to CMS. The raw data is used to respond to requests from researchers and ad-hoc requests from CMS, Congress or other agencies. Program statistics are available for download and review. These statistics are utilized by researchers to assist in defining a data request.

Impact: No Impact

External Request from Researcher for CCW Data

1. Researchers external to CMS will contact Research Data Assistance Center (ResDac) via phone, email or website to request CCW Data. ResDac is a CMS contractor providing free assistance to academic, government and non-profit researchers interested in using Medicare and/or Medicaid data for their research. The request may contain ICD codes or the request may be more general and require further refinement.

   Impact: No impact

2. ResDac Technical Advisors work with researchers to understand and define the data request. The original request may or may not have ICD codes. ResDac Technical Advisors may work with the requester to further define or narrow the request. This refinement of the request may require research on appropriate ICD codes to ensure the correct data is collected.

   Impact: No Impact
   - ResDac Technical Advisors will need to become familiar with ICD-10 codes to understand incoming requests and assist researchers in defining these requests. ResDac will be responsible for educating their staff on the changes in ICD codes and how designing research projects will be impacted. There is no system utilized to submit data requests requiring updates to accommodate ICD-10 codes.

3. ResDac submits request to CMS for approval for privacy issues by the Privacy Board. The Privacy Board will make certain the data requested can be classified under one of twelve

Privacy Act Disclosure Exceptions. These exceptions allow the release of information containing personally identifiable information.

Impact: No Impact

4. For approved requests, ResDac submits data requests for chronic care data to Iowa Foundation for Medical Care (CCW contractor). ORDI/IMG/SMDR has contracted with CCW contractor to build and maintain the data in the CCW. CCW contractor will work to fulfill the data request from the CCW. Data will be provided in a Microsoft Excel Spreadsheet or Statistical Analysis Software file format. The data supplied can have ICD codes. ResDac will also forward data requests to Research Data Distribution Center (RDDC) or directly to CMS Office of Information Services, for requests not related to chronic conditions.

   Impact: No Impact

   - CCW contractor will be responsible for training its staff to understand and be familiar with ICD-10 codes to comprehend and fulfill data requests. There may be some training necessary for CCW contractor to understand the changes for ICD-10 codes and changes to the CCW. The transition to ICD-10 will not change the current process for responding to data requests.

Request from Internal CMS Source for CCW Data

1. Requests for data or analysis related to Chronic Conditions can come from internal CMS sources, (e.g., Office of Policy, Office of External Affairs, Office of Clinical Standards and Quality (OCSQ) or other groups/divisions in ORDI) to ORDI/IMG/SMDR. These requests can be for raw data for future analysis by CMS or may be a request to respond to a specific question, requiring research or analysis of CCW data. Depending on the requester's knowledge and expertise, these requests may have ICD codes.

   Impact: No Impact

2. ORDI/IMG/SMDR will review and refine the request, if needed, and pass the request to CCW contractor. The requests can contain ICD codes or require research to determine which ICD codes should be used to resolve the request. Requests are at varied levels of detail, depending on the knowledge of the requester.

   Impact:

   ORDI/IMG/SMDR staff will need to become familiar with ICD-10 codes to understand incoming requests and assist researchers in defining and submitting requests. This impact is ***minor*.** There may be some training necessary to understand the changes for ICD-10 codes. There is no system utilized to submit data requests requiring updates to accommodate ICD-10 codes.

3. CCW contractor fulfills the request. The fulfillment may mean supplying data for analysis by the requester or actually performing analysis of the data and supplying the results.

   Impact: No Impact

   - CCW contractor will be required to train its staff on ICD-10 codes and the impacts on designing parameters for research requests. The transition to ICD-10 will not change the current process for responding to data requests.

4. CCW contractor provides the raw data or analysis results to the CMS internal requester.

   Impact: No Impact

Publication of Medicare and Medicaid *Statistical Supplement*

1. On an annual basis, ORDI/IMG/DIDA generates the Medicare data and ORDI/IMG/DRID publishes the *Statistical Supplement*. The first step in that process is to update code parameters to generate the tables/reports included in the supplement. This update may not happen every year and, if there are no changes, existing code parameters will be utilized. When there are updates, DIDA refers to the National Center of Health Statistics' list of frequently occurring diagnoses (provided by Center for Disease Control) to determine the parameters for building some of the supplement tables. The data used to create the supplement is at least 6 to 12 months old.

   Impact

   - These code parameters contain ICD codes, as some reports are focused on providing information on frequently occurring diagnoses or on tracking specific diagnoses, such as End Stage Renal Disease. These code parameters will need to change for the transition to ICD-10. These tables can present trends in data over multiple years or for a single year. In both situations, the parameters to generate the reports may have to account for the data containing both ICD-9 and ICD-10 codes. Research data is gathered based on the calendar year and the conversion to ICD-10 is currently planned to occur at the start of a fiscal year. This impact is modest*. Mapping for ICD-9 and ICD-10 codes exists to properly generate reports where ICD codes are utilized or examined.

2. ORDI/IMG/DIDA programmers build the Catastrophic File System and Annual Persons Summary File to utilize in the creation of the *Statistical Supplement*.

- To create the Catastrophic File System data is pulled from the Medicare Provider Analysis and Review (MEDPAR) File and Standard Analytical Files. The exchange contains ICD codes. The Catastrophic File System is owned and maintained by ORDI/IMG/DIDA.
- To create Annual Persons Summary (APS) File, data is pulled from the Standard Analytical File. The exchange contains no ICD codes. The APS File contains Medicare data summarized by individual. The APS File is owned and maintained by ORDI/IMG/DIDA.
- To generate the utilization tables, data is pulled from the MEDPAR and the Standard Analytical Files. The exchange contains ICD codes. The utilization tables contain Medicare data summarized by individual or by units of service.

Impact

- The programs for generating many of the utilization tables (as well as the programs for extracting the data from the SAFs) will require updating to accommodate the expanded field size of ICD-10 codes and maintain the ability to accommodate ICD-9 codes. In addition, any programming to build these files will have to be updated to enable processing ICD-10 codes, as well as ICD-9 codes. This impact is ***modest***.

3. ORDI/IMG/DIDA programmers utilize the parameters provided and produce the requested supplement tables. To create these tables, the programmers pull data from the following sources:

   - Denominator File. This file does not have ICD codes and stores enrollment information file from the Enrollment Database (EDB). Denominator File is owned by ORDI and maintained by Office of Information Services (OIS).
   - MEDPAR File. This file has ICD Codes. MEDPAR contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and skilled nursing facilities (SNF). MEDPAR file is owned and maintained by OIS/EDG/DIDPM.
   - Standard Analytical File (SAF). This file has ICD Codes. The SAF comprises seven data sets containing detailed final action claims information about health care services rendered to Medicare beneficiaries in fee-for-service Medicare. SAF is owned and maintained by OIS/EDG/DIDPM.
     - Annual Person Summary File. This file has no ICD Codes.
     - Catastrophic File System. This file has ICD Codes.

   The programmers utilize the Table Generation System to pull the data from the listed data sources and build the supplement tables. The Table Generation System is owned and maintained by CMS/ORDI/IMG/DIDA. The Table Generation System does not have its own repository, but uses ICD codes in the table generation process.

Specific Tables (Reports) in Statistical Supplement containing ICD coded data

- Table 5.5 – Short stay hospital utilization by principal ICD-9 diagnosis within Major Diagnostic Category (MDCs)
- Table 5.6 – Short stay hospital utilization by principal ICD-9 procedure within MDCs
- Table 6.6 – SNF utilization by principal ICD-9 diagnosis within MDCs
- Table 6.8 – SNF utilization by leading principal ICD-9 diagnosis (trend table)
- Table 7.6 – HHA utilization by principal ICD-9 diagnosis within MDCs
- Table 7.7 – HHA utilization by principal ICD-9 diagnosis (trend table)
- Table 9.8 – Physician/supplier utilization by principal ICD-9 diagnosis within MDCs
- Table 10.4 – Outpatient hospital utilization by selected ICD-9 diagnosis code
- Table 5.7 – Shows a trend of short stay hospital utilization data by leading diagnosis related group.

Impacts

ORDI/IMG/DIDA programmers may require training to understand changes to the tables/reports for ICD-10 codes. This impact is minor.
The Table Generation System (owned and maintained by CMS/ORDI/IMG/DIDA) will require modification to accommodate two sets of ICD codes. Supplement tables, providing information on one year or multiple years, may contain both ICD-9 and ICD-10 codes. Analysis of data for the Statistical Supplement is on a calendar year basis. ICD-10 is expected to be implemented on a fiscal year basis. The data for the first year will have nine (9) months of ICD-9 data and three (3) months ICD-10. The tables providing trends for multiple years will have to account for both code sets for several years. This impact is modest*. Alternatively, the ICD-9-CM – based tables can use a twelve-month reference period running from October through September.

4. The programmers provide the generated table to an ORDI/IMG/DIDA analyst. The analyst performs a trend analysis on the data and examines the data for any aberrations with comparative or historical data. If there are aberrations, the analyst will work with a CMS Subject Matter expert to resolve or understand the issue. The analyst may work with the programmer to better understand data changes.

   Impacts

   - ORDI/IMG/DIDA analysts may require training to understand changes to the tables/reports for ICD-10 codes. This impact is ***minor***.

5. Validated tables are then sent to ORDI/DRID for inclusion in the *Statistical Supplement*. The *Statistical Supplement* is then distributed to internal and external researchers, Division Directors and the Administrator via the CMS website. This supplement is provided to subscribers to the "Health Care Financing Review" and available on CD from the

Impact: No Impact

Process Risk Assessment

Collect and Deliver Chronic Condition Data Process

The primary impacts to the CCW processes and systems are:

a. Required planning and design work to update existing algorithms
b. Development of programmatic changes to the CCW algorithms
c. Updates to CCW to allow storage of expanded ICD-10 codes.

The risk associated with these impacts is that research data provided for internal or external requests would be compromised or invalid. This risk is ***modest***[60]**.** Although a crosswalk between ICD-9-CM and ICD-10-CM exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. The CCW algorithms will need to accommodate both ICD-9 and ICD-10 code sets for multiple years, as claims history from previous years is examined in the building of CCW data tables.

Training for CMS research personnel in ORDI/IMG/SMDR involved in development of CCW tables and responding to internal CMS research requests will be required to understand the differences between ICD-9-CM and ICD-10-CM as well as baseline knowledge for parameter development for reconciliation of the two coding systems. In addition, researchers will require a working knowledge of the mapping currently available. Without this training, ORDI/SMDR staff will not be able to fulfill their responsibilities related to the development of the CCW and for assisting with research projects.

The risk associated with this impact is ***minor***[61]**.** Education is an ongoing process and would be accomplished prior to the development of CCW.

Publication of Medicare and Medicaid *Statistical Supplement*

The *Statistical Supplement* tables contain ICD coded data and span multiple years. These code parameters utilized to build these tables will require change for the Transition to ICD-10. The tables can present trends in data over multiple years or for a single year. In both situations, the parameters to generate the reports may have to account for the data containing both ICD-9 and

[60] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

[61] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

ICD-10 codes. Research data is gathered based on the calendar year and the transition to ICD-10 is currently planned to occur at the beginning of a fiscal year. During the first year of transition, reports will contain 9 months of ICD-9-CM codes and 3 months of ICD-10-CM and ICD-10-PCS codes. Mapping between ICD-9 and ICD-10 codes exists to facilitate correlation of the two coding systems to properly generate reports where ICD Codes are utilized or examined.

The risk associated with incorrectly developing table parameters is ***minor*** as the tables are generated 12– 18 months after the implementation of ICD-10, allowing substantial time to properly plan and implement necessary changes.

Catastrophic File System and the Annual Persons Summary File will require updating to accommodate the expanded field size of ICD-10 codes and maintain the ability to store ICD-9 codes. In addition, any programming to build these files will have to be updated to enable processing ICD-10 codes, as well as ICD-9 codes. These systems rely on data from MEDPAR and SAF and will need to respond to changes in those data sources to accommodate for ICD-10 codes.

The risk to this process is ***modest*** due to potential data compromise for developed tables.

Training of programmers will be required to have a basic understanding of the differences between ICD-9-CM and ICD-10 codes. In addition, mapping knowledge will be required to fulfill data requirements for generated tables.

The risk to this process is ***minor***. Education is an ongoing process and would be accomplished prior to the development of tables 12-18 months after implementation.

Conduct Demonstrations Process
Impact Rank: Modest

Table 28. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Office of Research, Development, and Information (ORDI): Modest [62] (Yellow Level)	Office of Research, Demonstrations and Information (ORDI)/Medicare Demonstrations Program Group (MDPG) ranking: Modest (Yellow Level)	Office of Research, Development, and Information (ORDI)/ Research and Evaluations Group (REG) ranking: Modest (Yellow Level)

Process Overview

CMS conducts and sponsors a number of demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Demonstrations can vary in size and scope depending on the goal. In some instances, demonstrations can be compared to running an individual program where all aspects, such as enrollment, payment, education, quality measurement and claims processing, can be involved and need to be considered.

The three divisions within the Office of Research, Demonstrations and Information (ORDI)/Medicare Demonstrations Program Group (MDPG) primarily responsible for conducting demonstrations are Division of Payment Policy Demonstrations (DPPD), Division of Delivery System Demonstrations (DDSD), and Division of Health Promotion & Disease Prevention Demonstration.

Systems utilized for the planning of demonstrations and collection of demonstration data include, but are not limited to, the National Claims History (NCH), National Medicare Utilization Data (NMUD), Standard Analytic File (SAF) and Medicaid Statistical Information System (MSIS) or Medicaid Analytic eXtract (MAX). These systems contain ICD coded data.

The primary impacts for the ICD-10 transition are on the demonstrations spanning the transition from ICD-9 to ICD-10 coding standards. These demonstrations may need to collect data with both coding standards and may require updates or modifications to CMS systems to allow for the use of ICD-10 codes. A demonstration spanning the transition will have to determine how to best collect and evaluate one set of data with two coding standards. Demonstration set-up may require changes to CMS claims processing systems, payments systems or clinical assessment instruments. These modifications may have to be re-evaluated under the new ICD-10 coding standard. In addition, system modifications made for a demonstration may be affected as these CMS systems make their own modifications to account for ICD-10 codes. Demonstrations may require development of new applications or tools and

[62] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

those tools may require additional programming or modification to accommodate ICD-10 codes.

Although a crosswalk between ICD-9-CM and ICD-10 exists, trending of data over several years may be compromised as there is not a one to one correlation in all cases. Research for particular conditions will require additional effort to ensure all parameters for demonstration projects are fulfilled and, in some cases, may not be possible. Research and analysis of beneficiary ICD-9 coded data is integral to the development of demonstration projects and data analysis for payment structure refinements. Demonstration projects offer alternative methods to provide program benefits, unconventional payment structures and evaluation of data.

Current demonstrations utilizing ICD coded data for design parameters and outcome measurements and potentially impacted by the transition to ICD-10 are as follows:

- Electronic Health Records (EHR) Demonstration. This demonstration is designed to reward delivery of high-quality care supported by the adoption and use of electronic health records in physician practices. This initiative expands upon the foundation created by the Medicare Care Management Performance (MCMP) Demonstration. The goal of this 5-year demonstration is to foster the implementation and adoption of EHRs and health information technology (HIT) more broadly as effective vehicles not only to improve the quality of care provided, but also to transform the way medicine is practiced and delivered.
- Home Health Pay for Performance (HHP4P) Demonstration. This demonstration will offer incentive payments to a sample of Medicare home health agencies for maintaining high levels of quality care, or making significant improvement s in the quality of their services. HHP4P will be conducted in Illinois, Connecticut, Massachusetts, Georgia, Alabama, Tennessee, California between Jan. 08 and Dec. 09.
- Medicare Medical Home Demonstration. This demonstration will be conducted in up to 8 states to provide targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.)
- Medicare Care Management Performance Demonstration. This demonstration is designed to promote the use of health information technology and improve the quality of care for beneficiaries. Doctors in small to medium sized practices who meet clinical performance measure standards will receive a bonus payment for managing the care of eligible Medicare beneficiaries. The demonstration will be implemented in California, Arkansas, Massachusetts and Utah.
- Medicare Low Vision Rehabilitation Demonstration. This demonstration will examine the impact of coverage for vision rehabilitation services provided to Medicare beneficiaries with moderated to severe visual impairments, which cannot be corrected through surgery or glasses. Services may be provided in the office of physician or in the home and home environment by qualified physicians or occupational therapists, or by certified low vision rehabilitation professionals under the general supervision of the physician.

- Nursing Home Value-Based Purchasing. This demonstration is designed to assess the performance of participating nursing homes based on selected quality measures. Incentive payment awards are then made to those nursing homes that achieved a higher standard of quality care.
- Premier Hospital Quality Incentive Demonstration. This demonstration is a 3 year demonstration designed to determine if financial incentives are effective toward improving the quality of inpatient care. Hospital quality incentive payments are based on quality measures associated with 5 clinical conditions.
- Medicare Coordinated Care Demonstration. This demonstration tests whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs.
- Medicare Physician Group Practice Demonstration. This demonstration seeks to align incentives for physician groups to manage the overall care for patients. The demonstration encourages physician groups to proactively coordinate beneficiaries total heath care needs; provides incentives to physicians to provide services efficiently and effectively; rewards improvements and delivery of high quality care; and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries.
- Medicare Acute Care Episode (ACE) Demonstration. This demonstration has not started yet. It is designed to provide global payments for acute care episodes within Medicare fee-for-service (FFS). The focus will be on select orthopedic and cardiovascular inpatient procedures. ACE Demonstration goals are to: improve quality for FFS Medicare beneficiaries, produce savings for providers, beneficiaries, and Medicare using market-based mechanisms, improve price and quality transparency for improved decision making, and increase collaboration among providers.

Related Processes

The Conduct Demonstrations Process is connected to the Conduct Evaluations and Research Projects Process. Demonstrations and evaluations can operate simultaneously with the evaluation tracking and collecting data in an active demonstration.

Process Description

1. Demonstration mandates come from CMS (the ORDI/MDPG or the CMS Administrator), the Secretary, the Executive Office of the President and Congress. Demonstrations are also suggested in unsolicited proposals received by CMS from sources outside of CMS (general public). Demonstration prioritization is determined by Congress, the Secretary or the CMS Administrator.

   Impact: No Impact

2. The ORDI/MDPG takes the demonstration proposal with assigned priority and performs research to begin demonstration planning. ORDI/MDPG may work with a contractor to assist in the demonstration research. This research may involve analyzing historical CMS data (e.g., NCH, CWF, SAF or MSIS/MAX) to determine the correct parameters for implementing a demonstration. For example, claims history data may be examined to identify the types of claims to be paid in the demonstration.

   Impact:
   - Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. This impact is ***modest***.
   - ORDI/MDPG may require training to understand the difference between ICD-9 and ICD-10 to plan for new demonstrations and to take full advantage of the additional specificity provided by ICD-10. This impact is ***minor***[63].

3. The ORDI/MDPG may work with the ORDI/Research and Evaluations Group (REG) to evaluate the demonstration, in cases where an evaluation of a demonstration is mandated. Both groups work together early in the process of setting up a demonstration to ensure proper coordination. The demonstration needs to be designed in a way to collect the necessary evaluation data/information and the evaluation must be designed to properly evaluate the demonstration's goals and purpose. If there is an evaluation of the demonstration, this process links to the Conduct Evaluations and Research Projects Process.

   Impact:
   - Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. This impact is ***modest***. Coordination between MDPG and REG is required to account for potential collection of both ICD-9 and ICD-10 data in the design of a demonstration.

4. The ORDI/MDPG or the demonstration contractor determines the payment impact. A large percentage of CMS' demonstrations are focused on payment issues. The demonstration may require modifications to existing payment systems or policy to test or measure a proposed program change. ORDI/MDPG or the demonstration contractor will determine the systems or policies impacted and any payment options.

   Impact:
   - Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. This impact is ***modest***. Demonstration payment

[63] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

may be tied to diagnoses codes and/or procedure codes, requiring planning to accommodate for both code sets.

5. ORDI/MDPG or the demonstration contractor creates the basic design of the demonstration based on its research. For example, identification of target populations, education requirements, new quality measures or a new edit for claims in the Shared Systems may be documented. In some cases, development efforts may be required to create a new tool or system to collect additional clinical information. At this point in the demonstration process, the demonstration contractor may submit a design report to CMS to document the approach for the demonstration.

   Impact:
   - Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. In addition, ICD-10 changes for CMS systems utilized in the demonstration need to be understood to determine any downstream affects on the demonstration. This impact is ***modest***.

6. Based on the design and in some cases, specifically, the payment impact, the next steps in the demonstration process can vary. To implement the demonstration, there may be several different activities to be performed to change existing systems and create the necessary environment for the demonstration. The demonstration contractor and ORDI/MDPG work with groups inside CMS for any system or policy changes. These options are not mutually exclusive from one another and multiples of them may be required to implement a demonstration.
   - ORDI/MDPG writes Change Requests (CR) for changes in Fee for Service Systems. Based on the research conducted, a change to the ICD-9 codes may impact how ORDI/MDPG directs business partners. When CRs, particularly to a claim payment system, are required, MDPG collaborates with Center for Medicare Management (CMM) and Office of Information Services (OIS) to ensure request is implemented accurately. When creating a CR, MDPG collaborates with CMM to be sure they both understand the impact of the change to the payment systems.
   - ORDI/MDPG requests changes to Medicare Advantage and Prescription Drug System (MARx) for Managed Care demonstrations. MARx is owned by Center for Drug and Health Plan Choice (CDHPC) and maintained by OIS.
   - ORDI/MDPG determines with input from a variety of sources, depending upon the demonstration, what measures to use. ORDI/MDPG may develop its own data collection systems/methodology if there are none existing meeting the demonstration's requirements. ORDI/MDPG may work with the Office of Clinical Standards and Quality (OCSQ) to develop clinical measures used for a demonstration.

- ORDI/MDPG arranges demonstration payment policy outside of existing payment systems:
  - Single Payment Policy. Payment for demonstration will be at the end of demonstration and handled by demonstration contractor.
  - Demonstration Payment System (DPS). ORDI/MDPG uses DPS for situations where the demonstration's payment policy can not fit within normal payment systems. DPS is managed by Office of Financial Management/Division of Financial Strategy and Evaluations (DFSE). These are situations where payment may not be tied directly to the diagnosis or procedures in the claim; instead payment may be based on a different matrix, e.g., number of beneficiaries treated.
- ORDI/MDPG collaborates with OIS for development of new systems or software to gather data for the demonstration.
- Other Required Changes

Impact:
- Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. This impact is ***modest***.
- Demonstration changes to systems or policy may be impacted by the transition to ICD-10 for demonstrations active during the transition. ORDI/MDPG or the supporting contractor will need to determine how system changes for ICD-10 will impact the demonstration and any demonstration specific changes. New development may have to be modified to accommodate ICD-10 codes. This impact is ***modest.*** ORDI/MDPG or the contractor will need to investigate and fully understand the changes to CMS systems for ICD-10 transition and how those changes will impact active demonstrations. Additionally, they will need to investigate and implement any required ICD-10 focused changes to tools and applications developed for a demonstration.

7. The Demonstration contractor runs and manages the demonstration, working with ORDI/MDPG. Demonstrations routinely last an average of 3 to 5 years but can continue much longer.

   Impact:
   - Demonstrations starting prior to the transition from ICD-9 to ICD-10 coding standard need to be designed to account for the transition and potential of gathering data using both coding standards. This impact is ***modest***. Demonstrations active during the transition and collecting ICD-9 data will have to implement system and process changes to accommodate ICD-10 codes. The Demonstration contractors will have to provide information to demonstration participants on how the transition may affect the demonstration processes and systems.

8. The Demonstration contractor completes the demonstration. In most cases, an evaluation contractor prepares a final findings report on the demonstration. The demonstration may deliver a closing report to be reviewed and approved by ORDI. The

- The evaluation assesses the effectiveness of the demonstration (examples, financial incentive for performance improvement on continuity of care, health outcomes, quality of care, patient satisfaction, physician satisfaction, and Medicare expenditures using Medicare claims data and results from patient and physician surveys, the demonstration and comparison practices). These data may or may not be dependent on ICD-9 codes.

Impact: No Impact

- This impact is on the Evaluation Contractor submitting the final report. This impact will be in full in the Conduct Research and Evaluation Projects Process.

Process Risk Assessment

MDPG's processes and demonstrations will be impacted as a result of the transition to ICD-10. If ICD data is incorrectly collected, analyzed or mapped to ICD-10 data, the outcome findings and report conclusions may result in invalid data with a potential outcome of under/over payments being allocated to providers. This risk is ***modest***[64]**.**

MDPG will require education on the technical differences between the two coding standards and to account for the differences when designing and implementing demonstrations. Demonstrations requiring clinical quality data collection may be affected by the transition from ICD-9 to ICD-10. ORDI/MDPG and demonstration contractors may need to change data parameters or plan for differences in the data as well. Changes such as re-coding, mapping, rework, communication to external entities and the impact it may have on the business partners will require evaluation. Future demonstrations may require additional funding to extend or re-start the demonstration if transition parameters are not properly planned. Provider participation may be affected or limited if the demonstration is impacted by transition issues, for example, collection tools for assessment data can not accommodate ICD-10 or usage is difficult.

[64] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

Conduct Evaluations and Research Projects Impact Rank: Modest

Table 12Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Office of Research, Development, and Information (ORDI): Modest[65] (Yellow Level)	Office of Research, Development, and Information (ORDI)/ Research and Evaluations Group (REG) ranking: Modest (Yellow Level)	Office of Research, Development, and Information (ORDI)/ Medicare Demonstrations Program Group (MDPG) ranking: Modest (Yellow Level)

Process Overview

The Office of Research, Development and Information (ORDI)/Research and Evaluations Group (REG) conducts studies and performs evaluations focused on Medicare Parts A, B, C and D, as well as Medicaid and special populations. The REG is comprised of three divisions: the Division of Research on Health Plans & Drugs (DRHPD); the Division of Research on Traditional Medicare (DRTM); and the Division of Research on State Programs & Special Populations. Each division within the REG is responsible for handling the research and evaluations for a program or programs within CMS. Some of these analysis activities may utilize ICD-9 data, as well as Medicare Severity-Diagnosis Related Groups (MS-DRG). The REG provides analysis information for both CMS and Congress to facilitate further studies, research and refinements in provider payment systems. Evaluation requests are received from ORDI management, the CMS Administrator, the Secretary of Health and Human Services (HHS), the Executive Office of the President, and Congress. In addition, the REG receives unsolicited requests and proposals from the general public. Prioritization of the REG's analysis activities is based on both internal and external requests, and is balanced against competing priorities and resources. Evaluation contractors assist the REG with the design and implementation of evaluations, and, as needed, analysis of data to facilitate report completion. Evaluation findings are prepared, reviewed and approved by the ORDI/REG. Reports may be distributed to the Secretary, other CMS divisions/components, or Congress. Research is conducted on a retrospective basis, usually utilizing three years of data. Much of the ORDI's research and analytical information is based on ICD-9 codes and MS-DRG data. MS-DRGs are created within the CMS claim payment systems and utilize specific ICD-9 code sets.

The Common Working File (CWF), National Claims History (NCH) files, Medicare Beneficiary Database (MBD), Enrollment Database (EDB), Medicaid Analytic Extract (MAX), Drug Data Processing System (DDPS) are utilized for data extraction in the "conduct evaluation process." In addition, the ORDI/REG or the evaluation contractor may utilize the Decision Support Access Facility (DSAF) via the Data Extract System (DESY) to extract data. The CWF, NCH and MAX all contain ICD-9 coded data.

[65]A Modest or Yellow Level Process will have an impact that, if the impact occurs, will cause small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

The primary impacts of the ICD-10 transition are on the evaluations spanning the transition from ICD-9 to ICD-10 coding standards. These evaluations may need to collect data using both code sets, and may require updates or modifications to CMS systems to allow for the use of only ICD-10 codes. An evaluation spanning the transition to ICD-10 will need to determine how to best collect and evaluate one set of data with two code sets for multiple years of data.

Research and analysis of beneficiary ICD-9 coded data is integral to the development of evaluation projects and data analysis. Although a crosswalk between ICD-9-CM and ICD-10 exists, trending of data over several years potentially may be compromised, as there is not a one-to-one correlation in all cases. Research for particular conditions will require additional effort to ensure all parameters for evaluation projects are fulfilled, and in some cases this may not be possible.

Related Processes

The Conduct Evaluations and Research Projects Process may be linked to the Conduct Demonstrations Process. Demonstrations and evaluations can operate simultaneously, with the evaluation process both tracking and collecting data for an on-going demonstration. In many cases, the evaluation process will create the final report on the findings at the completion of the demonstration.

Process Description

Prioritization

1. Evaluations are performed and managed by the ORDI/REG. Evaluation mandates are submitted from ORDI management, the CMS Administrator, the Secretary, the Executive Office of the President, or the Congress. Unsolicited proposals/requests may also be submitted by the general public. Demonstrations requiring an evaluation may initiate this process, with the ORDI/REG coordinating their efforts with the ORDI/Medicare Demonstrations Program Group (MDPG). Prioritization is usually determined by Congress, the Secretary and/or the CMS Administrator. The scope of an evaluation or research project may differ, depending on the initiating request. Requests can vary from an evaluation for a multi-year demonstration, or an ad-hoc request from a member of Congress. The types of requests may include:
    - Raw data
    - Specific program statistics.
    - An intramural or extramural research request.
    - Request for a demonstration evaluation.
    - Request for a program evaluation or study of a specific payment policy

    Impact: No Impact

Designing/Planning for Studies

2. The ORDI/REG designs and plans evaluations or research projects. Multiple data sources are utilized during the designing step of an evaluation. The CMS data sources can include claims data, enrollment data, assessment data, or new primary data. The ORDI/REG may conduct a survey, or may add a question to the on-going Medicare Beneficiary Survey (MCBS). The MCBS is a continuous, multipurpose survey of a representative national sample of the Medicare population, conducted by the ORDI.

   Impact:
   - The ORDI/REG staff will require training to understand the differences between ICD-9 and ICD-10 coding standards. This impact in ***minor***[66].
   - The ORDI/REG will need to accommodate the ICD-10 transition when planning evaluations. This impact is ***modest***. Data collected or analyzed for an evaluation may contain both ICD-9 and ICD-10 codes. As there is not a one-to-one mapping between ICD-9 and ICD-10 codes, additional analysis will be required to determine how the change in ICD codes will impact outcomes of a particular evaluation or research project.

Securing Contractors

3. The ORDI/REG works with a contractor to plan and initiate the evaluation environment. The ORDI/REG and the contractor collaborate to ensure the necessary data can be collected, or is available to complete the evaluation's goals. Data collection may be tied to an on-going demonstration, or the research project may require the review of existing CMS Medicare or Medicaid data.

   Impact:
   - The ORDI/REG will need to account for the ICD-10 transition when planning evaluations. This impact in ***modest***.

Conducting Studies

4. The ORDI/REG or the evaluation contractor conducts the evaluation. Depending on the focus of the evaluation, the systems and data sources used may vary. The ORDI/REG and the evaluations are categorized as being focused on Medicare Part A and Part B, Medicare Part C and Part D and Medicaid.

Review of Medicare Part A and B Data

- The ORDI/REG or the evaluation contractor may access National Claims History (NCH) data, the Common Working File (CWF), the Enrollment

[66] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

Database (EDB) and/or the Medicare Beneficiary Database (MBD) to gather the data necessary for studies. The ORDI/REG has used the Decision Support Access Facility (DSAF), which is owned by the Office of Information Systems (OIS)/Enterprise Data Group (EDG), and accessed via the Data Extract System (DESY), which is owned by OIS/EDG. The CWF and NCH contain ICD-9 codes. In the future, the Integrated Data Repository (IDR) will become a data source for these studies.

Review of Medicare Part D Data

- The ORDI uses Part D data from the Drug Data Processing System (DDPS). This data does not contain ICD codes. The DDPS is owned by the Center for Drug and Health Plan Choice, and maintained by OIS.
- The REG uses data from the Risk Adjustment for Policy and Operations process for research. The data reviewed may or may not contain ICD codes.

Review of State Medicaid Data

- Researchers use the Medicaid Analytical Extract (MAX) to conduct evaluations. The MAX is a set of person-level data files of Medicaid eligibility, service utilization, and payments. The MAX data is an extract of the Medicaid Statistical Information System (MSIS). The MAX development process combines MSIS initial claims, interim claims, voids, and adjustments for a given service into this final action event.
- In addition, researchers may use commercial sources of prescription drug information, First Data Bank and MediSpan. These are therapeutic groupers for prescription drugs. These groupers do not utilize ICD codes.

Impacts:

- Following the transition to ICD-10, data sources (e.g., the CWF and NCH) utilized for evaluations will contain both ICD-9 and ICD-10 coded data. This impact is ***modest***. The ORDI/REG or the evaluation contractor will be required to determine how to evaluate or trend data with both coding standards for evaluations when data is collected before and after the transition to ICD-10.
- The systems and data sources utilized for evaluations will be impacted by the transition to ICD-10. The ORDI/REG or the evaluation contractor will need to account for these system changes for on-going evaluations, as well as evaluations in the planning stages. This impact is ***modest***. The ORDI/REG or the evaluation contractor will be required to react to changes in other systems, and maintain the ability to gather and evaluate data. Specifically, the ORDI/REG or the evaluation contractor conducts evaluations focused on Medicaid specific issues and relies on Medicaid data sources (e.g., MSIS and MAX) for those evaluations. Medicaid data comes into CMS from the individual states. There is the possibility that states may

have different compliance dates for the transition to ICD-10, as well as dates that differ from each other, and from CMS. In addition, there is the possibility that there may be different transition dates for data collected by individual state contractors. The ORDI/REG will need to determine how to handle Medicaid evaluations when examining data spanning the timeframe of the ICD-10 transition, to accommodate the potential for different transition dates.

5. The ORDI/REG or its research contractor completes the study. In many cases, the evaluation contractor may prepare a final report to submit findings to CMS. For demonstration evaluations, the findings report will provide results and analysis of a completed demonstration. The reports are then reviewed and approved by ORDI/REG. These reports may be distributed to the Secretary, other divisions and/or components within CMS, or Congress.

   Impacts:

   - The ORDI/REG will need to determine methods of analyzing data with two coding standards for those evaluations spanning the transition, particularly those studies relying on ICD codes. This impact is ***modest***. Coded data analysis may span over multiple years when researching data, requiring trending of the historical data. ICD-10 is expanded to accommodate specificity of disease processes, and although a crosswalk/mapping exists, there is not a one-to-one correlation between the two ICD coding classifications.

Process Risk Assessment

The REG's processes and evaluations will be impacted as a result of the transition to ICD-10. If ICD-9 data is incorrectly collected, analyzed or mapped to ICD-10 data, the findings and report conclusions may result in invalid data, potentially limiting the ability to draw conclusions or successfully fulfill the goals of the evaluation. The REG will require education on the technical differences between the two coding standards, and account for the differences when designing evaluations. The ORDI/REG and its research contractors may need to change data parameters, or plan for differences in the data. Changes such as re-coding, mapping, reworking, and communicating to external entities the impact of the ICD-10 transition on study outcomes may be necessary. Coded data analysis may span over multiple years when researching data, requiring trending of the historical data. ICD-10 is expanded to accommodate specificity of disease processes, and although a crosswalk/mapping exists, there is not a one-to-one correlation between the two ICD coding classifications. Future evaluations may require additional funding to extend or re-start the evaluation if transition parameters are not properly planned. This risk is ***modest***[67].

[67] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project

The ORDI/MDPG collaborates with ORDI/REG on demonstration evaluations, participating in the planning and generation of final report. If the ORDI/REG ICD-10 transition impacts are not properly managed, evaluations of demonstrations may not achieve desired outcomes or analysis. This risk is ***modest***. Additional work may be required by REG and MDPG to collect and validate demonstration data and complete the analysis.

Medicaid Integrity Operations Oversight Impact Rank: Modest

This process description has been redacted due to recent changes in the program's structure that now necessitate its revision. Given the nature of this process, only revised, non-proprietary information regarding Medicaid Integrity Operations Oversight and ICD-10 implementation will be posted to this website at a future date.

Medicaid Policy and Operations
Impact Rank: Modest

Table 30. 13Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Centers for **Medicaid Policy and Operations Process Rank: Medium**[68] **(Orange Level)**	Center for Medicaid and State Operations (CMSO)/ Disabled and Elderly Health Programs Group (DEHPG) / Division of Eligibility, Enrollment and Outreach (DEEO): Minor[69] (Green Level)	Center for Medicaid and State Operations (CMSO)/ Family and Children's Health Program Group (FCHPG)/ Division of Benefits, Eligibility and Managed Care (DBEMC): Minor (Green Level)	Office of Information Systems (OIS)/ Enterprise Databases Group (EDG)/ Division of Integrated Data Program Management (DIDPM): Minor (Green Level)	Center for Medicaid and State Operations (CMSO)/ Finance, Systems and Budget Group (FSBG)/ Division of State Systems (DDS): Modest[70] (Yellow Level)	Center for Medicaid and State Operations (CMSO)/ Finance, Systems and Budget Group (FSBG)/ Division of Information Analysis and Technical Assistance (DIATA): Medium (Orange Level)	Office of Research, Development and Information (ORDI)/ Research and Evaluations Group (REG): Modest (Yellow Level)

Process Overview

There are six processes associated with Medicaid Policy and Operations:

- Develop Medicaid Policy
- Publish Medicaid Policy
- Approve State Program Waivers
- Conduct Mandated Pay and Chase Policy
- Fund and Certify Medicaid Management Information System (MMIS) Operation
- Receive and Distribute Medicaid Claims Data

[68] A Medium or Orange Level Process will have an impact that, if the impact occurs, will cause noticeable cost (and/or schedule) increases to the project.
[69] A Minor or Green Level Process will have an impact that, if the impact occurs, will cause little or no measurable impact to cost (and/or schedule) of the project.
[70] A Modest or Yellow Level Process will have an impact that, if the impact occurs, will cause small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

The Develop Medicaid Policy process identifies the drivers for the creation of Medicaid policy. Drivers include Congressional mandates and the Centers for Medicare & Medicaid Services (CMS) and state initiatives. Of the numerous Medicaid policies, the following were identified as being impacted by the transition to ICD-10:

- The Pay and Chase policy owned by the Division of Eligibility, Enrollment and Outreach (DEEO) within the Disabled and Elderly Health Programs Group (DEHPG) of the Center for Medicaid and State Operations (CMSO)

- The Family Planning Services and Waiver policies owned by the Division of Benefits, Eligibility and Managed Care (DBEMC) within the Family and Children's Health Program Group (FCHPG) of CMSO

- The Medicaid Management Information System (MMIS) Certification and Funding policy owned by the Division of State Systems (DDS) within the Finance, Systems and Budget Group (FSBG) of CMSO

The Publish Medicaid Policy process identifies how Medicaid policy is disseminated to the states. CMSO groups and divisions commonly use letters to State Medicaid Directors and/or Associate Regional Administrators to communicate policy to the states. Additionally, the State Medicaid Manual is used to a limited extent to communicate policy to the states. Two Medicaid policies containing ICD-9 codes were identified. After ICD-10 implementation, updates to these policies would need to be communicated to the States. CMSO/DEHPG/DEEO would be required to communicate updates for the Pay and Chase policy and CMSO/FCHPG/DBEMC would need to communicate updates for the Family Planning Services policy.

The Approve 1115 Family Planning State Program Waivers process depicts the process surrounding the submission, review, and approval of state waivers. Although various groups and divisions within CMSO review 1115 state waivers, CMSO/FCHPG/DBEMC is only responsible for reviewing section 1115 waivers related to family planning. In that regard, waivers reviewed by CMSO/FCHPG/DBEMC containing ICD-9 codes would be affected by the transition to ICD-10. CMSO/FCHPG/DBEMC is responsible for reviewing a state's family planning waiver application, amendment or renewal and assuring the ICD-9 codes listed are contained within the master list of codes developed and retained by CMSO/FCHPG/DBEMC. CMSO/FCHPG/DBEMC will be responsible for updating the master list of codes and reviewing the updated state family planning waivers with the transition to ICD-10.

The Conduct Mandated Pay and Chase Policy process outlines the requirement for states in the payment of claims for certain identified high risk and vulnerable populations. The Pay and Chase policy is an exception to the Third Party Liability policy. The Third Party Liability policy mandates states establish and maintain an effective Third Party Liability (TPL) program to reduce Medicaid expenditures. States utilizing their Medicaid Management Information System (MMIS) identify claims containing a third party payer other than Medicaid. The

identified claims are then sent to the identified third party payer for payment as Medicaid is always the payer of last resort. The Pay and Chase policy identifies three categories of high risk populations as exceptions to the TPL policy. Claims identified with an ICD-9 code for one of the three categories are paid first; reimbursement is then chased from the third party payer. The Pay and Chase policy and the corresponding ICD-9 codes are located in the Pay and Chase Policy section of the State Medicaid Manual. The primary impact to this process is that CMSO/DEHPG/DEEO, the component responsible for the Pay and Chase policy, will be required to update the policy during the ICD-10 implementation. The states will be responsible for updating their MMIS with ICD-10 codes identified.

The Fund and Certify MMIS Operation process outlines the process of states requesting funding for their MMIS and the certification of the MMIS system. CMSO/FSBG/DSS is responsible for reviewing and approving MMIS budget requests. Once the MMIS system has been installed or upgraded the Regional Office in coordination with CMSO/FSBG/DSS will certify the MMIS. The implementation of ICD-10 will result in all state MMIS systems requiring upgrading and recertification. States may also request additional funding for the administrative costs involved with the implementation of ICD-10. CMSO/FSBG/DSS will be responsible for the review and approval of the administrative cost requests. The primary impact on CMSO/FSBG/DSS will be a temporary increase in workload to process the increased amount of funding and administrative cost requests from the states.

The Receive and Distribute Medicaid Claims Data process depicts the process of the states creating tapes of Medicaid claims data from their MMIS and forwarding the tapes to be loaded into the Medicaid Statistical Information System (MSIS) at CMS. The Division of Integrated Data Program Management (DIDPM) within the Enterprise Databases Group (EDG) of the Office of Information Systems (OIS) receives the tapes and is responsible for the edits performed on the tapes. The Division of Information Analysis and Technical Assistance (DIATA) within FSBG of CMSO is responsible for overseeing the performance of statistical and validation editing of the data. Upon approval of the data by the validation contractor, OIS/EDG/DIDPM will load the MMIS data into MSIS. OIS/EDG/DIDPM is system maintainer and CMSO/FSBG/DIATA is the business owner of the three data marts which receive MSIS data once loaded. The primary impact to CMSO/FSBG/DIATA and OIS/EDG/DIDPM will be the updating of the MSIS and the three data marts with the transition to ICD-10.

Related Processes

The Receive and Distribute Medicaid Claims Data process is interrelated to the Conduct Evaluation Research. The Research and Evaluations Group within the Office of Research, Development and Information access the Medicaid claims data and create the Medicaid Analytic Extract.

The Receive and Distribute Medicaid Claims Data process is interrelated to the Medicaid Integrity Operations Oversight process. The Medicaid Integrity Group within CMSO access

the raw Medicaid claims data which is loaded into the Medicaid Integrity Program System (MIPS).

Process Description

Develop Medicaid Policy

1. Congressional mandates, legislation and both CMS and state initiatives are inputs into the development of Medicaid policy. Of the numerous Medicaid policies, the following policies were identified as being impacted by the transition from ICD-9 to ICD-10:
    - The Pay and Chase Policy owned by CMSO/DEHPG/DEEO
    - The Develop Family Service and Waiver Policies owned by CMSO/FCHPG/DBEMC
    - The Develop Medicaid Management Information System (MMIS) Certification and Funding Policy owned by CMSO/FSBG/DSS

Impact*: No Impact*

Publish Medicaid Policy

1. Once developed, Medicaid policy is disseminated to the states. The three identified methods of distributing new policy and changes to existing policy are:
    - Updates to the CMSO owned State Medicaid Manual for the pay and chase process. The State Medicaid Manual is published on the CMS website
    - State Medicaid Director letters
    - Associate Regional Administrator letters

Impact*:*

- CMSO/DEHPG/DEEO is responsible for updating the Pay and Chase Policy section of the State Medicaid Manual, which will need to be updated to note the change to ICD-10 codes. Additionally CMSO/DEHPG/DEEO may utilize a State Medicaid Directors letter to communicate the updated Pay and Chase Policy to state Medicaid offices. The impact is ***minor***.

- No additional sections of the State Medicaid Manual requiring mapping of ICD codes as a result of the transition to ICD-10.

Approve 1115 Family Planning State Program Waivers

1. States submit 1115 family planning program waivers to CMSO/FCHPG/DBMEC. Once received, CMSO/FCHPG/DBMEC considers the waiver request.

CMSO/FCHPG/DBMEC is responsible for reviewing each state's family planning service waiver and assuring the ICD-9 codes listed in the waiver are contained within the master list of codes maintained by CMSO/FCHPG/DBMEC. The master list of family planning codes consists of approximately ten ICD-9 diagnosis and procedure codes for contraception and sterilization.

Impact:

- With the implementation of ICD-10, the current ICD-9 codes need to be mapped accurately to ICD-10 codes. The level of effort needed to accomplish this is minimal. The person responsible for updating the master list would require some basic ICD-10 training in order to perform the updating. The impact is ***minor***.

- Analysts within CMSO/FCHPG/DBMEC are responsible for reviewing the codes (ICD-9, CPT and HCPCS codes) to be covered under the state family planning services waiver. The review is a manual process requiring minimal analysis of the ICD-9 codes. The analysts would require basic ICD-10 training in order to understand the differences between ICD-9 and ICD-10 codes. The impact is ***minor***.

2. Upon completion of their review of the submitted waivers, CMSO/FCHPG/DBMEC will obtain approval for their decisions. The approval process consists of: negotiations with each state for the waiver, vetting of the decisions within CMS, and final approval from the Office of Management and Budget (OMB). Once final approval has been reached, CMSO/FCHPG/DBMEC returns a final waiver decision to the states for implementation in their Medicaid program.

Impact: ***No Impact***

Conduct Mandated Pay and Chase Policy

1. The states, using the MMIS system, identify claims for third party liability. This process involves identifying those claims containing another third party payer other than Medicaid. Since Medicaid is considered the payer of last resort, every effort is made to identify and reroute claims to the identified third party payer. The data used to identify these claims are coverage and eligibility data.

Impact: ***No Impact***

2. Once third party liability has been established, the state makes a determination of whether or not the claim is eligible for the pay and chase process. States are required to load the ICD-9 codes listed in the Pay and Chase Policy section of the

State Medicaid Manual into their MMIS systems. The MMIS system then edits claims and identifies those claims containing ICD-9 codes eligible for the Pay and Chase process. Three categories are identified under the Pay and Chase policy: prenatal care for pregnancy women, preventative pediatric services, and child support. Claims not meeting the Pay and Chase criteria are rejected and sent back to the provider with instructions to bill the liable third party payer.

Impact:

- States will be required to reprogram their MMIS systems with ICD-10 codes for identification of claims meeting the Pay and Chase criteria. States will review the updated Pay and Chase Policy section of the State Medicaid Manual to identify the specific ICD-10 codes. The impact is ***minor***.

3. Claims meeting the Pay and Chase policy are paid by the state. The state is mandated by law to submit payment to the hospital or provider within 30 days of receipt of the claim.

Impact: ***No Impact***

4. After the claim has been paid, the state will send a reimbursement request to the identified third party payer. Once the request has been received, the third party payer will submit reimbursement to the state for the pay and chase claim.

Impact: ***No Impact***

Fund and Certify MMIS Operations

1. CMSO/FSBG/DSS receives budget requests and operating plans from the states for their MMIS systems. CMSO/FSBG/DSS is responsible for reviewing the budget requests and making the determination of whether or not to approve the budget request. Once a state has either installed a new MMIS or implemented upgrades to their existing MMIS, the system must be certified. The certification process is performed by the Regional Office and is required before a state can receive federal matching funds for their MMIS. The Regional Office utilizes a certification check list when performing the certification. The check list is created and updated jointly by CMSO/FSBG/DSS and the Regional Offices. CMSO/FSBG/DSS is also responsible for reviewing and approving requests from the states for funding for Administrative costs. Additionally, CMSO/FSBG/DSS provides states with technical assistance and support for their MMIS.

Impact:

- The transition to ICD-10 will result in a temporary increase in workload to CMSO/FSBG/DSS. Every state will be required to upgrade their MMIS systems to accommodate ICD-10 codes. Each state will request federal funding for these upgrades. Additionally, CMSO/FSBG/DSS will receive an

increased number of requests for funding to cover administrative costs that the states incur as a result of the ICD-10 implementation. Since all states will have to upgrade their MMIS systems, the certification process workload will also increase. The certification checklist will need to be updated to accurately reflect changes required for ICD-10 implementation. CMSO/FSBG/DSS will also experience an increase in requests from the states for technical assistance and support. The impact is ***modest***.

2. The states will conduct Medicaid operations including receipt of claims from hospitals and providers. These adjudicated claims will be stored in each state's MMIS system.

Impact: ***No Impact***

Receive and Distribute Medicaid Claims Data

1. The states using the MMIS system performs mapping of Medicaid data. Once mapped, the MMIS system creates extracts of the collected Medicaid data. The developed extracts are loaded onto data tapes and forwarded to OIS/EDG/DIDPM. This step can be connected to the Medicaid Integrity Operations Oversight. The Medicaid Integrity Group take the Medicaid claims data contained in the tapes and load the data into the Medicaid Integrity Program System (MIPS).

Impact: ***No Impact***

2. OIS/EDG/DIDPM receives and stores the MMIS data tapes in the Foreign Tape Library. OIS/EDG/DIDPM will perform surface edits and relational edits on the data. A file of the edited data is created and forwarded to CMSO/FSBG/DIATA.

Impact:

- The transition from ICD-9 to ICD-10 will require that the systems used by OIS/EDG/DIDPM be updated to receive and perform the edits required on the MMIS data. If states transition to ICD-10 at different times, the systems used by OIS/EDG/DIDPM to receive and perform the edits would need to be able to accommodate both coding classification systems. CMSO/FSBG/DIATA will be responsible for overseeing the changes to the editing and report generating functions. The impact to this process is ***minor***.

3. Upon receipt of the file with edited data, CMSO/FSBG/DIATA will forward the file to the validation contractor. The validation contractor will perform statistical and validation editing on the data.

Impact:

- CMSO/FSBG/DIATA will be responsible for ensuring the validation contactor is able to receive and edit Medicaid claims data containing ICD-10 codes. The impact to this process step is ***minor***.

4. Once the validation contractor performs the edits, they will notify CMSO/FSBG/DIATA as to whether the data files are approved. If the files are approved by the validation contractor, then CMSO/FSBG/DIATA will forward a request to OIS/EDG/DIDPM to load the MMIS data. Claims data not passing the validation contractor's edits will be sent back to the states for correction and re-submission.

Impact: ***No Impact***

5. The Research and Evaluations Group (REG) within the Office of Research, Development and Information (ORDI) accesses the Medicaid claims data and create the Medicaid Analytic Extract (MAX). The MAX flat file captures person level details including eligibility, service utilization, and payments. MAX is used to support research and policy analysis. This step can be connected to the Conduct Evaluation process.

Impact:

- The flat file used to collect and forward Medicaid data to the MAX must be modified to accept ICD-10 codes. MAX will need to accept code from both coding classification systems if the states transition to ICD- 10 is not concurrent. The impact is ***modest***

6. Upon receipt of request from CMSO/FSBG/DIATA, OIS/EDG/DIDPM will load each quarter's data into the Medicaid Statistical Information System (MSIS) data warehouse utilizing system utilities and COBOL.

Impact:

- CMSO/FSBG/DIATA will be responsible for overseeing the reprogramming of the MSIS to accommodate a larger field size to store the ICD-10 codes. The MSIS does not contain any algorithms that analyze data. The claims data from the state data tapes is loaded into MSIS and stored in its mainframe tables. The tables will need to be expanded to receive both ICD-9 and ICD-10 codes. Due to the states different fiscal calendars and budgetary cycles, implementation of MSIS upgrades may not happen concurrently. The transition of all states to ICD-10 will take an extensive period of time. The impact is ***modest***.

7. OIS/EDG/DIDPM is responsible for overseeing the creation of three data marts from the data stored on MSIS:

    - Web Based data mart

- Claims Level data mart
- Person Level data mart

The data marts are accessed, using COGNOS, by CMS components including ORDI, Office of the Actuary, and the Medicaid Integrity Group. The person level data mart is used to flag seven disease conditions: AIDS/HIV, Asthma, Delivery, Diabetes, Mental Health, Substance Abuse, and Long Term Care Institutional Status. The specific disease conditions are flagged, using ICD codes, and are used for academic research by the Congressional Research Service, the Urban Institute, and Kaiser.

Impact:

- The seven disease conditions are flagged using ICD codes. OIS/EDG/DIDPM will need to ensure the ICD9-to ICD-10 crosswalk is accurate codes to ensure proper reporting on these conditions. The impact to this process step would be ***minor***.

Process Risk Assessment

Pay and Chase Process

The Pay and Chase Process employs ICD-9 codes to identify the high risk, vulnerable populations which require their claims to be paid first by Medicaid. Medicaid then chases after other third party payers for reimbursement. As the State Medicaid Manual (SMM) only lists a sample of codes for illustrative purposes, CMSO/DEHPG/DEEO will update the policy described in the SMM during the ICD-10 implementation. Additionally, utilizing the updated State Medicaid Manual, states will be required to update their MMIS systems with ICD-10 codes. Incorrect updating of the MMIS systems could result in inaccurate identification by the state of beneficiaries eligible for the Pay and Chase policy. There may be a delay in reimbursement if eligible pay and chase claims are not correctly identified. Conversely, if cases are inaccurately identified as being eligible for pay and chase, the result may be improper disbursement of funds to ineligible claims. This risk is ***minor***[71].

Family Planning Services Waivers

A master list of family planning codes is utilized by CMSO/FCHPG/DBEMC to review state Family Planning Services waivers. During the implementation of ICD-10, CMSO/FCHPG/DBEMC will be required to update the master list with ICD-10 codes. They will also be required to review the ICD-9 codes covered under each approved state

[71] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

Family Planning Services waiver to assure compliance with updated ICD-10 codes in the CMS master list. Due to the limited number of ICD-9 codes used in the Family Service waivers and the master list of codes the risk to this process is ***minor***.

Fund and Certify MMIS Process

States will require funding to upgrade their MMIS and additional administrative costs due to the implementation of ICD-10. In additional, state MMIS will need to be recertified to assure the system has been correctly upgraded to accommodate the changes necessary for ICD-10. Although the recertification process will result in a period of increased workload to CMSO/FSBG/DSS, the risk for this process is ***minor***.

Medicaid Statistical Information Management System (MSIS)

The MSIS will require reprogramming by CMSO/FSBG/DIATA in order to accept ICD-10 codes. If the field code size in MSIS is not upgraded prior to states sending ICD-10 data to MSIS, the ICD-10 data fields will be truncated resulting in the coding data being of no value. There is the possibility the states will not transition to ICD-10 during the same time; this will result in MSIS receiving both ICD-9 and ICD-10 codes for an extensive period of time. Since MSIS only stores code and does not perform any analysis on the codes, it was felt that receiving both code sets for an extended period of time would not be an issue. The data from MSIS is also loaded into three data marts with the person level data mart containing flags identifying claims containing the codes of one of the seven identified disease conditions. The logic used to identify the seven disease conditions will need to be accurately mapped with ICD-10 codes. The overall risk to MMIS and its associated data marts is ***modest***[72].

[72] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

Provider Cost Report Process
Impact Rank: Modest

Table 31. Process Summary Report ICD-10 Implementation Impact Ranking

Overall Process Rank for Provider Cost Report Process Rank: MODEST[73] **(Yellow Level)**	Office of Financial Management (OFM) /Financial Services Group (FSG)/ Division of Provider Audit Operations (DPAO) (Yellow Level)	Office of Information Systems (OIS) /Business Application Management Group (BAMG)/ \Division of Business Application Analysis /(DBAA) (Yellow Level)

Process Overview

Medicare-certified institutional providers are required to submit an annual cost report to their Medicare Fiscal Intermediary or Medicare Administrative Contractor (FI/MAC). This summary report details the systems involved and activities performed by CMS, FIs/MACs and providers to complete and submit the providers' annual cost reports. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. The Medicare data (based on claims) is obtained from the Provider Statistical & Reimbursement (PS&R) Report. FIs/MACs provide summary PS&R reports to providers to complete their cost reports. Providers, then, submit annual cost reports to the FIs/MACs. The FIs/MACs utilize the PS&R reports to reach final settlement with providers for Medicare payments. Note – the PS&R System is currently being redesigned, and providers will eventually be able to obtain their own PS&R reports directly from the system.

The PS&R system provides reports to institutional providers to assist in the creation and editing of their annual cost reports. The PS&R system is owned and maintained by Division of Provider Audit Operations (DPAO) within the Office of Financial Management\Financial Services Group (OFM/FSG). OFM/FSG develops, implements, manages, and oversees policy and systems requirements for CMS' contractors and financial management systems. The PS&R System is populated daily with claims data from the Fiscal Intermediary Shared System (FISS) Paid Claim File. FISS is owned and maintained by Office of Information Systems\Business Application Management Group\Division of Business Application Analysis (OIS\BAMG\DBAA). The process for handling institutional claims and creating the FISS Paid Claim File (the primary input to PS&R) is documented in the Process Institutional Part A and Part B Claim process. The claim information in the FISS Paid Claim File contains International Classification of Diseases (ICD)-9-CM (Clinical Modification) coded data.

The primary impacts for the ICD-10 Transition on the cost reporting process are the reformatting of the FISS Paid Claim File and updates to PS&R System to store expanded ICD-

[73] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

10 codes. OIS\BAMG\DBAA will be required to update the FISS Paid Claim File to accommodate expanded ICD-10 codes. To facilitate the processing of the updated FISS Paid Claim File, DPAO will be required to make corresponding updates to the PS&R System to receive and store claims file with updated/expanded ICD-10 codes. The changes required for PS&R System are limited, since ICD codes are stored in the PS&R System, but not utilized in reporting.

Related Processes

Preceding the Provider Cost Report process is the Institutional Part A and Part B Claims process. The PS&R receives a daily feed of the FISS Paid Claim File containing detailed institutional claims information. The FISS Paid Claim File contains ICD codes. The PS&R and Provider Cost Report process have no outputs with ICD data.

Process Description

1. The PS&R System (owner/maintainer OFM\FSG\DPAO) receives daily feeds of the Paid Claim File from FISS. The claim information contains ICD coded data. PS&R performs some basic editing of the file, but no edits are focused on ICD codes. The Process Institutional Part A and Part B Claims process provides inputs (FISS Paid Claim File) to the PS&R, which is used for the cost report.

Impacts

- The PS&R System (owner/maintainer OFM\FSG\DPAO) will require updating to accommodate the expansion of ICD-10 coded data passed from FISS. The PS&R system stores ICD coded data, but does not utilize ICD codes when generating provider reports. The primary impact will be accommodating the ICD Code expanded field size from the updated FISS Paid Claim File. This impact is ***modest***. The changes to the PS&R System are limited to increasing the field size. The redesigned PS&R System will be implemented in 2008. The initial release of the redesigned version will be able to accept the new FISS paid claim file layout, which includes an update to specific fields to accommodate ICD-10 codes. For any future FISS paid claim file changes, the PS&R will need to be updated.
- FISS Paid Claim File will require updates to accommodate expanded ICD-10 codes. OIS\BAMG\DBAA will be responsible for these updates. This impact is modest. The changes to the FISS Paid Claim File for the ICD-10 transition will be limited to accommodating the increase in field size for ICD-10 codes.

2. OFM\FSG\DPAO using the PS&R System makes the data for the Provider Summary Report and Diagnosis Related Group (DRG) Summary Report available to providers. Providers are able to access the redesigned PS&R System to request reports on their claims data by specifying the report and a specific time period. The reports once generated are provided in an electronic format for download, as an Adobe Acrobat Portable Data File (PDF) or in Comma-Separated Variable (CSV) file format.

- Provider Summary Report summarizes claim data and other information by revenue code required for cost report settlement and CMS reporting purposes. Time periods included are specified by the provider.
- DRG Summary Report is a supplement to the Provider Summary Report and is a summary of prospective payment data broken out and summarized by DRG categories. The DRG Summary Report is an optional report for providers, requiring additional information to develop their cost report.
- Impact: No Impact

3. Payment Reconciliation Reports (PS&R Detail Reports) can be requested by the provider. This report contains personal health information and the report is generated and provided by the FI/MAC in a secure method. Providers are supplied one free report a year and are required to pay for any additional copies. This report is utilized to understand any differences between a provider's records and the information in the Provider Summary Report or DRG Summary Report.
   - Payment Reconciliation Report contains detailed claims information to support the Provider Summary Report. The Payment Reconciliation Report serves as an audit trail for claims activities and as a comparison to the summary reports. There will be DRGs on this report, but no ICD codes.
   - Impact: No Impact

4. Providers use the Provider Summary reports and optionally, the Payment Reconciliation Report and DRG Summary Report, to develop their cost report. Providers must be able to explain or resolve any variances between the PS&R reports and their own cost report.
   - Impact: No Impact

5. Providers submit the Cost Report to FIs/MACs on an annual basis.
   - Impact: No Impact

6. The FI/MAC will conduct an audit of the Provider Cost Report and obtain the latest provider cost data from PS&R, by building the Provider Summary Report. The audit will demonstrate any adjustments to the records. Once the audit process is complete, the FI/MAC will reach final settlement with the cost report.
   - Impact: No Impact

7. Summary level data for all cost reports is made available for public and internal CMS use via Healthcare Cost Report Information System (HCRIS) which is owned by OIS/BAMG/DBAA and maintained by OIS/EDG. Specifically, the cost report summary data is used by the Office of Actuary and Center for Medicare Management. The summary level data does not contain ICD codes therefore, no impact is identified.
   - Impact: No Impact

Process Risk Assessment

The Provider Cost Report for Medicare Part A Claims Process will rely on OIS\EDG\DBAA properly implementing ICD-10 changes to the FISS Paid Claim File and will rely on OFM\FSG\DPAO implementing the appropriate changes to the PS&R System for ICD-10 codes. If these required changes are not implemented properly, the risk to the cost reporting process is delayed access to information utilized by providers and by CMS contractors (FIs/MACs). The lack of reliable data for the cost reports would prevent or delay the annual financial reconciliation between CMS and Medicare Part A providers. Delayed submission of a provider cost report may affect the provider's ongoing or future payments from CMS.

The risk associated with these two impacts, updates to FISS Paid Claim File and PS&R System, is ***modest***[74].

Although ICD coded data is stored in the PS&R system, it is not included or utilized in the generation of cost reports. The PS&R system is currently being re-designed and may require future adjustments to accommodate expanded ICD-10 code field size. The risk of any potential problems resulting from updates to the PS&R System will be minimized due to the recent reengineering effort and use of latest programming standards.

[74] A Modest or Yellow Level Process has the potential for small cost (and/or schedule) increases that, in most cases, can be absorbed by the project.

Summary of Findings Impact Rank: No Impact/Minor

Overview

The minor or no impact section includes the Centers for Medicare and Medicaid Services (CMS) components and the related processes that were determined to have a minor or no impact during the assessment activities reviewing the policies, procedures and systems impacted by the transition from ICD-9 to ICD-10. This section is organized by CMS Office and Group, and provides a high level description of the organization along with the process(es) that were identified (if any) during the overview interviews. For processes that were identified to have a medium, modest or high impact, a detailed interview was conducted as well as a detailed process report produced. These can be found in the Process Details section of this report. The components (Office/Group) within CMS that own processes or functional areas described to have a minor impact are described within this section. Assessment findings for divisions described within this section include an impact, risk and cost assessment ranking where applicable. In many cases it was determined during the interview process that the impact of implementing ICD_10 would be minor to the component and therefore additional specific details regarding the component were not gathered during the assessment activities. In these cases, a general impact assessment was provided without specific risks or costs impacts. Listed below are the Offices and Groups that were determined to have a minor or no impact:

Center for Drug and Health Plan Choice (CPC) [75]

Employer Policy & Operations Group (EPOG)

The former Employer Policy & Operations Group (EPOG) of the Center for Beneficiary Choices (CBC) is responsible for the management and oversight of healthcare and prescription plan programs offered to eligible beneficiaries through sponsoring employers and unions.

The three divisions making up EPOG are responsible for Medicare enrollment activities as they may relate to employers, unions, health plans, prescription plans and retirees; ICD-9 information is not utilized by EPOG divisions nor does it factor into their day-to-day activities.

Impact

Through the Overview Interview process, it was determined a transition to ICD-10 will have ***no impact*** on EPOG business processes and systems.

EPOG divisions do not utilize ICD-9 information nor does it factor into their day-to-day activities. Therefore, EPOG has determined a transition to ICD-10 will present no risk to their group. We do not believe the transition to ICD-10 will have a noticeable cost impact on EPOG.

[75] CBC, now the Center for Drug and Health Plan Choice (CPC) was reorganized in June 2008 and the functions of EPOG were dispersed across four of the five current groups (Medicare Drug Benefit and C&D Data Group (MDBUG), Medicare Drug and Health Plan Contract Administration Group (MCAG), Medicare Enrollment & Appeals Group (MEAG), and Medicare Plan Payment Group (MPPG))

Center for Medicaid and State Operations (CMSO)

Financial Management Group (FMG)

The Financial Management Group (FMG) within the Center for Medicaid and State Operations (CMSO) is responsible for Medicaid and State Children's Health Insurance Program (SCHIP) financial policy issues, reimbursement and state financing, and performs financial management operations. FMG is responsible for the development of Medicaid and SCHIP budgets and grants, financial management policy and administrative cost policy and analysis of state's budget estimates submitted on the Forms CMS-37 and CMS-21B. The States also submit the CMS-64 forms which reports the actual expenditures made by each state during the quarter. FMG analyzes the data from the CMS-64 reconciling expenditures to the state's budget advance which, in turn, affects the States letter of credit. A similar process is completed with the CMS-21 forms for SCHIP budget estimates and expenditures. State budget reports and reconciliation of State expenditure reports and monthly accounting reports utilizes the automated Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) (Medicaid Budget and Expenditure System (MBES) and SCHIP Budget and Expenditure System (CBES)). MBES/CBES is a consolidated budget and expenditure database which allows the States to electronically enter their budget and expenditure forms on line. The MBES/CBES and the processes related to the system utilize aggregated financial data from the states. FMG develops, interprets and applies specific laws, regulations and policies directly governing the financial operation and management of the Medicaid and SCHIP programs. FMG also reviews State Medicaid program funding mechanisms to ensure consistency with established policies on provider related donations, health care related taxes, certified public expenditures, intergovernmental transfers and State and local appropriations to verify allowable status as non-Federal sources.

Processes Identified

The following was identified and will have ***minor***[76] impacts as a result of the ICD-10 transition

FMG does not manage any ICD-9 related processes, instead the business operations of this group is limited to financial management operations and the oversight of policies related to Medicaid reimbursement and state financing.

Impact

The impact to implementing ICD-10 is ***minor*** as it may result in increased budget requests from States which may impact the analysis and historical trending of State Medicaid data performed by the FMG.

[76] A Minor or Green Level Process has the potential for little or no measurable impact to cost (and/or schedule) of the project.

Risk Assessment

FMG functions and processes are not involved with ICD-9 codes; the risk to this group is ***minor***[77].

Cost Implications

There will be a ***minor***[78] cost impact to this group as a result of ICD-10 changes. The identified costs that may be incurred by this group are related to a portion of the States' administrative expenses which will be incorporated into Advance Planning Documents (APDs). APDs are managed by the Finance, Systems and Budget Group (FSBG) in CMSO.

Office of the Actuary (OACT)

The National Health Statistics Group (NHSG)

The National Health Statistics Group (NHSG), within the Office of the Actuary, is responsible for producing economic and statistical estimates and analysis of historical and projected health spending, provider profit margins, and market basket indexes.

The NHSG is responsible for producing the National Health Expenditure Accounts (NHE), which is an annual series of statistics presenting total national health expenditures spanning from 1960 through 2006. The group breaks this data down further to produce complement reports of health spending by age, state of residence, and state of provider as well as both short and long range health spending projections.

NHSG produces CMS market baskets. Market baskets are fixed weight price indexes that track the changes in provider input costs and are used to update the various payment mechanisms for different providers. NHSG also analyzes provider margins utilizing data abstracted from the CMS costs reports, Healthcare Cost Report Information System (HCRIS) database.

NHSG works closely with the Organization for Economic Cooperation and Development (OECD). OECD is an international organization of thirty member countries which provides a setting where governments compare policy experiences and collect comparable statistics on economic and social data.

NHSG provides the United States (U.S.) health statistics to OECD, which enables the comparison of the U.S. to other OECD member countries.

Processes Identified

The following processes were identified but will not be impacted:

1. Produces the National Health Expenditures Accounts

[77] A Minor or Green Level Process with risks of minimal or routine modifications to the process.
[78] A Minor or Green Level Process with costs less than $100,000.

2. Produces CMS Market Baskets
3. Analyzes provider margins utilizing data from HCRIS
4. Provides U.S. statistics to OECD

The data NHSG works with in producing the NHE is largely aggregate level data, at the provider, insurer/payer level. Economic Census data produced by the Census Bureau is used in the production of the NHE and will include data collected by ICD-9 code (2007 data), but it is not likely to impact NHSG processes since the data is also collected at the total revenue level separately from the breakdown by disease. The change to ICD-10 will likely have no impact on the aggregate data currently used in producing the NHE report. There are future projects slated within the OECD that will compare country specific data based on ICD-10 codes.

NHSG also utilizes data from The Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), which includes ICD-9 codes. However, NHSG uses this data for analytical purposes and to derive age and gender based spending ratios used to estimate national health spending by age.. NHSG has no current plans to use disease level data in the future production of any economic or statistical analysis of health spending or finance that is produced by this division.

The analysis of provider margins based on Medicare Cost Report data is a separate NHSG analysis, and does not include ICD-9-based data.

Impact

It has been determined through interviews that there are ***no impacts*** to NHSG processes.

Risk Assessment

Based on the information obtained during the overview interview with NHSG, it has been determined that no perceived risks exist to the processes performed by the group during the transition from ICD-9 to ICD-10. This conclusion is based on the fact that the data NHSG works with is aggregate level data, largely at the provider, insurer/payer level. The data is used to describe trends, not estimate them.

Cost Implications

Based on the overall findings of ***no impact*** to NHSG processes, it is safe to conclude there would not be any subsequent cost implications during the transition to ICD-10.

Office of Acquisition and Grants Management (OAGM)

Processes Identified

The following process was identified and will have a ***minor*** impact from the ICD-10 transition:

- Award and Administration of Contracts and the Award and Administration of Grants

The Office of Acquisition and Grants Management (OAGM) acknowledged they do not have any processes or systems containing IDC-9 coded data. The initial identified risk for OAGM is ***minor***. With sufficient advance notice and proper outreach and education regarding the requirement to transition to ICD-10, Program Offices should be able to properly plan and execute required contract changes and address any additional funding for grants with assistance from OAGM. There is some potential risk for OAGM not being able to handle the workload for additional contract or grant actions in a timely manner if there is a substantial increase in contract actions (modifications, re-bids or new awards) or grant awards at one time.

Office of Beneficiary Information Services (OBIS)

Website Project Management Group (WPMG)

The Website Project Management Group (WPMG) within the Office of Beneficiary Information Services (OBIS) coordinates the formulation of website policies, strategies, goals, and standards for three Centers for Medicare & Medicaid Services (CMS) websites, www.medicare.gov (Medicare.gov), www.cms.hhs.gov (CMS.gov), and the CMS Intranet. WPMG does not contain divisions.

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

Receive Website Update Request Process

WPMG works with supporting contractors (e.g. CGI Federal) and requesting components to ensure webpage updates are correctly presented to CMS.gov website users. Individual components are responsible for updating their own CMS.gov webpage content using Stellent content management software. WPMG manages how information is displayed on the site, not the actual content of information.

Impact: A transition to ICD-10 will have a ***minor*** impact on WPMG's "Receive Website Update Request Process" since individual components are responsible for submitting their own content updates. It is anticipated the update process will not be significantly impacted even if the volume of component update requests increases with the demand to meet an ICD-10 implementation date.

Support Webpage Display Process

WPMG supports the webpage display process, however, since components provide ICD-9-related web content, the components will need to inventory and update their web content to reflect changes resulting from a transition to ICD-10. For example, Center for Medicare Management (CMM) may need to update Medicare Severity Diagnosis Related Groups (MS-DRG) information, Office of Clinical Standards and Quality (OCSQ) may need to update quality measure information and components such as CMM, may need to update ICD-9 web

page content with ICD-10 content. ICD-9 codes are used to derive MS-DRG and quality measures information and the actual calculations are completed by the individual components before the aggregate information is made available via webpage content. Therefore, the individual components posting MS-DRG or quality measure data will need to recalculate their information and update their website content. Web pages currently displaying specific ICD-9 code information may need to display both ICD-9 and ICD-10 information after the transition to ICD-10. One possible solution may be to add new web pages for ICD-10 while continuing to display past ICD-9 content on the website. Clarification from the CMM coding team indicates the current convention for differentiating ICD- 9 Codes and updated codes is to designate the old code in parentheses separating former and new codes. (Prescription drug information may not need to be updated at this time since ICD-9 codes are not yet associated with prescription data.)

The number of web pages to be updated is not known at this time. WPMG may be able to assist components with inventories through webpage searches. The resources and time required to perform inventories and updates may also need to be considered in order to accurately assess the impact of updating webpage content. WPMG does not foresee concerns about increased database space needs or increased website traffic to add webpage updates.

Impact: The transition to ICD-10 presents a ***minor*** impact to the WPMG activities supporting content display activities.

Release Website Change Process

Similar to updating webpage content, website services (tools) and products may need to be added to the websites. WPMG works with components such as Office of External Affairs (OEA), Center for Drug and Health Plan Choice (CPC), OCSQ, CMM and Center for Medicaid and State Operations (CMSO) to test and make Agency-compliant changes to the tools available on www.cms.hhs.gov and www.Medicare.gov. With a transition to ICD-10, website releases could be delayed for a short period of time if ICD-10 changes are delayed or backlogged in other components. Unlike the updates required for webpage content, the current CMS website tools do not use or provide ICD-9 information and will not require website releases related to ICD-10. For example, tools (e.g. Hospital Compare, Plan Finder, etc.) do not currently offer website users the ability to search by diagnosis code and retrieve ICD-related information, nor do the tools use database tables for calculating or displaying ICD-code information. WPMG does not foresee concerns related to website releases and a transition to ICD-10.

Impact: Therefore, it is anticipated transitioning to ICD-10 will have a ***minor*** impact on the "Release Website Change Process."

Refresh Website Process

Website refreshes are not related to webpage content such as the display of ICD-9 information. Website refreshes are typically performed to update the general appearance of existing websites

with a new or modified layout, new color schemes or flash images for additional interest. Although specific process information was not provided, refreshes could be delayed for a short period of time if ICD-10 changes are delayed or backlogged in other components.

Impact: WPMG does not foresee concerns related to website refreshes and transitioning to ICD-10 will have a ***minor*** impact on the process.

Each component is responsible for updating their webpage content. Therefore, it is their responsibility to ensure webpage content is updated to reflect ICD changes. The risks associated with failing to update relevant webpage content (e.g. Internet Only Manuals, transmittals, policies, regulations, coverage determinations, etc.) do not reside within WPMG. The risks are associated with the components providing ICD-9 related webpage content. The risk to WPMG is ***minor***.

Due to an increase in component webpage updates, website releases or refreshes may be postponed for a short period of time. This may cause a delay in posting current and accurate website information. WPMG does not foresee this as a concern for their group. Therefore, the risk to WPMG is ***minor***.

Based on the statements during the Overview interview, the cost impact on OBIS/WPMG is expected to be ***minor***. The WPMG website maintenance process performed by this Group does not interact with ICD-9 codes. ICD-9 content relevant to ICD-9 (such as transmittals, manuals, etc.) is developed by other components within CMS.

Office of Clinical Standards and Quality (OCSQ)

Coverage and Analysis Group (CAG)

The Coverage and Analysis Group (CAG) within the Office of Clinical Standards and Quality (OCSQ) is responsible for developing National Coverage Determinations (NCDs) and overseeing the Local Coverage Determination (LCD) process. CAG develops determinations of whether or not a new or existing item or service will be covered by Part A and Part B Medicare. We make these determinations public through decision memoranda which are posted on the CMS Coverage website. All final NCDs are published in the Medicare NCD Manual. All decision memoranda and the NCD manual can be found on the CMS Coverage website. Additionally, CAG has oversight of the twenty-three clinical lab NCDs and the clinical lab edit table.

CAG is also responsible for overseeing the LCD process. All LCDs are developed by the local Medicare contractors (e.g., MACs, FIs, carriers). LCDs are coverage decision made for each respective local contractor jurisdiction. LCDs cannot supersede or conflict with NCDs or other national coverage policies.

Processes Identified

The following process was identified and will have a ***minor*** impact.

National Coverage Decision Change Requests

Once an NCD has been developed, instructions in the format of a change request must be written to provide implementation instructions to the Medicare contractors. In some instances, the change request contains the ICD-9 diagnoses and/or procedure codes that must be used in order for the item or service to be paid by Medicare. CAG works with the Center for Medicare Management (CMM) to assist in identifying the appropriate ICD-9 codes to be issued in the contractor instructions (i.e., the change request). The Medicare contractors utilize the codes outlined in the change request to assist them in creating edits to identify those claims which must be paid based on the NCD.

Impact
The impact to the CAG for this process will be ***minor***. With the transition to ICD-10, CAG will be required to use ICD-10 codes for any new NCDs after ICD-10 is in effect. It takes approximately nine to twelve months to implement a NCD, which would allow CAG adequate time to identify appropriate ICD-10 codes. For all the current NCDs (approximately 450 NCDs), CAG staff (analyst and medical officer) must review each NCD to determine which contractor instructions must be updated with the new ICD-10 codes. This will require extensive staff time to review these NCDs to ensure it is properly coded.

In addition to NCDs, there are approximately 5,000 LCDs that must be reviewed by Medicare contractors to ensure proper coding. This workload must be reviewed by our Medicare contractors to determine the impact on the program.

Clinical Standards Group (CSG)

The Clinical Standards Group (CSG) within the Office of Clinical Standards and Quality (OCSQ) is responsible for the development of Conditions of Participation and Conditions for Coverage for the Medicare and Medicaid programs. The Conditions of Participation and Conditions for Coverage are the minimum health and safety requirements that providers and suppliers must meet in order to receive Medicare and Medicaid funding. Each of the twenty-two providers/suppliers has their own set of requirements.

There are two divisions within CSG: the Division of Institutional Quality Standards (DIQS) and Division of Non-Institutional Quality Standards (DNIQS). DIQS is responsible for the development of the Conditions of Participation and Conditions of Coverage for the institutional providers and DNQS develops those for the non-institutional suppliers.

Processes Identified

The following was identified and will have no impact.
The Conditions of Participation and Conditions for Coverage do not contain ICD-9 codes; therefore CSG's processes are not involved with the use of ICD-9 codes. Additionally, the usual systems that CSG utilize to perform their work is Excel and Access and the information that they receive from other CMS components does not usually contain any ICD-9 codes. The transition to ICD-10 will have no impact to CSG.

Risk Assessment

No direct risks to this group have been identified. Processes are projected to continue with no modifications.

Cost Implications

There will be no cost impact to SCG as a result of the ICD-10 transition.

Office of External Affairs (OEA)

Creative Services Group (CSG)

The Creative Services Group (CSG) of the Office of External Affairs (OEA) produces tangible products carrying the Agency's message to the public, beneficiaries and to partners. CSG uses various venues, e.g. print, website, audio seminars, multimedia, cable show, satellite broadcast. The primary audience for the partner training products is the beneficiary. CSG provides consultation services and support for OEA and CMS components in achieving strategic communication objectives by providing expertise in plain language documentation and Spanish translations. CSG is a new group, brought about by reorganization to bring all CMS staff creating communication products into one group. The group is not involved with ICD-9 coded data, but does anticipate involvement in a transition to ICD-10 as it relates to Agency messages to beneficiaries.

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

Producing Communication Products

Similar to the OEA Media Relations Group (MRG), CSG does not utilize ICD-9 codes in any manner. However, the group does anticipate some participation in future activities related to the ICD-10 implementation. This work will be a part of the day-to-day activities CSG performs to produce communication products. CSG does not anticipate a significant workload increase or change in standard materials for a transition to ICD-10.

Impact: Therefore, it is expected a transition to ICD-10 will have a ***minor*** impact on CSG business processes.

CSG activities do not include interactions with ICD-9 information. However, CSG may assist with media materials related to a transition to ICD-10. The risk to CSG increases when a "roll-out" impacts the beneficiary, however in the transition to ICD-10, it is anticipated the change will be transparent to the beneficiary. The CSG anticipates a transition to ICD-10 will present a ***minor*** risk to their group.

We believe the transition to ICD-10 will have, at most, a ***minor*** cost impact on the OEA/CSG.

Medicare Ombudsman Group (MOG)

The Medicare Ombudsman Group (MOG) of the Office of External Affairs (OEA) provides guidance to the Agency to identify and resolve systemic issues in order to assist individuals entitled to health care benefits. MOG assesses Medicare program policy, operations, and the impact on beneficiaries in order to ensure beneficiaries are able to access their benefits. MOG receives, analyzes, monitors, and reports on beneficiary inquiry/complaint data, trends and performance of Medicare beneficiary programs in coordination with all CMS components receive and track beneficiary inquiries and complaint information. The Medicare Ombudsman was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

Beneficiary Access to Benefits

Although the processes have not been defined in detail, MOG receives and responds to beneficiary inquiry/complaint data in coordination with all CMS components receiving and tracking beneficiary inquiries and complaint information - e.g. Call Center Operations Group (CCOG) and Regional Offices (RO). MOG also responds to complaints, grievances and requests for information submitted by individuals (and their advocates) entitled to benefits under Parts A, B, C, and D with respect to any aspect of the Medicare program. This process is not typically associated with ICD-9 related issues.

Impact: However, if plans to effectively implement ICD-10 fail or are problematic, beneficiary services and/or claim payments could be negatively impacted. A negative impact to beneficiary services and claims may result in an indirect impact to MOG causing an increase in beneficiary inquires to MOG, Regional Offices, CCOG and State Health Insurance Program (SHIPs). To mitigate unforeseen systemic problems created by the transition to ICD-10, MOG suggests additional training on ICD-10 codes to MOG staff, ROs, and caseworkers.

Next Generation Desktop (NGD) and Common Working File (CWF) are two systems currently used by MOG to view claim information related to a beneficiary complaint or grievance. Among other claim data, NGD and CWF allow MOG staff to view ICD-9 information.

MOG will need high level training on the difference between ICD-9 and ICD-10 code changes in these systems. MOG views claim data; the Group does not create or receive ICD-9 specific information. MOG does not change, update, manipulate, analyze or trend ICD-9 data. To ensure preparedness and training for Central Office and Regional MOG staff, MOG will need to know the projected implementation dates as soon as available. MOG staff will need additional training on how ICD-10 codes impact the claims processes; MOG will not need training on details such as ICD code characteristics. The Group conducts weekly and monthly

calls where training may be provided and may off-set additional training time. MOG also conducts regional assessments asking Regional staff to identify additional training needs related to ICD-10.

Impact: Currently, it is anticipated there may be a ***minor*** impact involving training.

There is ***minor*** risk to MOG activities if erroneous claim payments result from the transition to ICD-10. Resources and costs may increase due to an increase in complaint volume. MOG identified the largest risk for their group as provider systems problems during ICD-10 implementation, resulting in inappropriate claims processing. MOG staff would work with other CMS components to quickly develop a fact sheet detailing appropriate communication for beneficiaries. MOG may need to utilize other CMS resources/staff to process volume (similar to the process utilized during the Part D implementation).

MOG does not proactively review ICD-9 codes, but it is possible MOG will become involved if a code-specific issue was identified impacting beneficiaries. MOG would need to analyze potential policy changes and/or communicate appropriate messages.

MOG staff will need to be trained on ICD-10. MOG will also need to assess how much training is required for caseworkers, and the level of detail of training required. Depending on the type of training needed, the transition to ICD-10 may require MOG to develop a training plan.

We anticipate the direct cost impact of the transition will be at most ***minor***. The cost to provide minimal ICD-10 training to caseworkers should result in minor costs. In the unlikely event issues with the transition lead to a large increase in beneficiary complaints, the cost is still minor.

Media Relations Group (MRG)

The Media Relations Group (MRG) of the Office of External Affairs (OEA) administers all operations related to external press releases and media inquiries. MRG activities focus on outreach to external press entities, beneficiaries and the healthcare industry in general. Outreach subjects primarily focus on CMS policies and regulations impacting the public. MRG collaborates with the Administrator and CMS components to identify press release topics, target audiences and the best methods to inform the public. Similar to the Office of Legislation and the Office of Policy, MRG is responsible for translating highly technical press information into language better understood by the general public. MRG is also responsible for preparing and releasing Agency press releases and Fact Sheets for external press organizations. For internal purposes, MRG creates Questions & Answers, Talking Points and scripts for internal purposes as guides to information to be shared during press conferences. MRG also collaborates with State Partner Organizations, such as the State Offices of the Aging, State providers and State Medicaid agencies, to create outreach strategies, or “roll-outs,” to identify release topics, target audiences and media materials to educate the public. With respect to these CMS outreach and relations responsibilities, MRG anticipates involvement in a transition to ICD-10.

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

Release Information through the Media Process

Although MRG does not utilize ICD-9 codes in any manner, the group anticipates participation in future activities related to coordinating and disseminating public information about the ICD-10 implementation. MRG will be responsible for working with Office of E-Health Standards and Services (OESS) to identify target audiences and appropriate media materials needed for future press releases related to the ICD-10 transition.

The process to release information through media begins when MRG, the Administrator or a CMS component identifies the need for a press release or press release campaign. MRG collaborates with the appropriate Agency components to identify target audiences, media methods and media materials. In order to create meaningful media materials and to accurately respond to press inquiries, MRG staff will need to understand the technical aspects and implications of implementing ICD-10. MRG will also need to understand the potential impact to the public, e.g. providers, payers and beneficiaries. Materials are either drafted by MRG and reviewed by the technical experts within CMS or drafted by technical experts and reviewed by MRG. In the case of ICD-10, the Center for Medicare Management (CMM) is considered the technical expert. Once materials are drafted, MRG circulates the materials to the respective components for review. The next step in the internal review process is approval from the Office of the Administrator. After Administrator approval, the materials are sent to the Assistant Secretary of Public Affairs for final review. Once final approval is received, MRG releases the information to press. Typically, the time required to complete the press release process, from initial drafting through final posting is bout 2 weeks. Following a press release, MRG may respond to related inquiries from the press.

With ICD-10, two audience messages are anticipated: one for the technical audience and one for the general public. Occasionally a general release contains links to information more technical in nature. MRG does not anticipate a significant workload increase or change in standard press release materials for a transition to ICD-10. Therefore, it is expected a transition to ICD-10 will have a ***minor*** impact on MRG business processes.

MRG has determined the transition to ICD-10 will present a ***minor*** risk to their group. MRG activities do not include interactions with ICD-9 information. However, MRG will be responsible for public press releases related to a transition to ICD-10. MRG has expressed the need to understand ICD-10, therefore training should be provided to this Group. Of note, MRG has completed large-scale projects requiring an internal redistribution of work within MRG only. If a transition to ICD-10 creates additional work for MRG, the group anticipates an easy redistribution of the workload within their group.

The transition to ICD-10 is a far-reaching initiative, and the need for follow-up actions is anticipated. The process would not consist of isolated press releases, but a dialogue between the Agency and the world, involving MRG.

We do not believe the transition to ICD-10 will have any noticeable cost impacts on MRG.

Partner Relations Group (PRG)

The Partner Relations Group (PRG) of the Office of External Affairs (OEA) serves as a resource to the Agency for facilitating collaborative relationships between CMS and a variety of national, state and local organizations, and between all CMS components, to promote awareness of Medicare and/or Medicaid benefits and other Agency initiatives. PRG works to ensure beneficiaries are aware of and receive Medicare and/or Medicaid benefits through these organizations. PRG manages relationships on behalf of all of CMS with external organizations. Although PRG does not utilize ICD-9 codes in any manner, the transition to ICD-10 will involve provider outreach on behalf of beneficiaries.

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

OEA Provider Outreach Process

OEA PRG provides communications to beneficiaries through Medicare providers. For the transition to ICD-10, PRG foresees the need for the following beneficiary communications:

1. Beneficiary Fact Sheet – General information about the transition to ICD-10
2. Provider Fact Sheet – Provider-specific information about the transition to ICD-10
3. Other Fact Sheet for Providers – Explains why a beneficiary may contact a provider about ICD-10 and what the transition means to beneficiaries.

Impact: In order to provide timely communication materials, PRG will need to be aware of the ICD-10 implementation timeline. PRG expects communication materials related to the transition will be a part of their regular work. Therefore, the anticipated impact to PRG is considered ***minor***.

CMM Provider Outreach Process

PRG works closely with the Provider Communications Group (PCG) in the Center for Medicare Management (CMM) to communicate with providers. PRG will work with PCG to produce provider communications related to the transition to ICD-10. Communication vehicles may include: webinars, provider information phone calls, open door forums and the Physicians Regulatory Issues Team (PRIT). PRIT is a group of CMS subject matter experts who work with the provider community to reduce the regulatory burden on physicians who participate with the Medicare Program. PRG also holds a position on an American Medical Association

workgroup, which may serve as an additional communication vehicle if needed. Additional "Open Door Forums" could be held as another means of communication.

Impact: In order to produce timely communication materials, PRG will need to be aware of the ICD-10 implementation timeline. PRG will also need to coordinate provider communications with PCG in CMM. PRG expects communication materials related to the transition to ICD-10 will be part of their regular work. Therefore, the anticipated impact to PRG is considered ***minor***.

For the transition to ICD-10, PRG does not foresee additional training needs nor do they have concerns about a significant increase in work. Therefore, PRG anticipates the transition to ICD-10 presents a ***minor*** risk to their activities. PRG and PCG have been proactive by communicating about the transition to ICD-10. In the normal business process, materials will be developed to communicate the changes to providers and beneficiaries. The transition to ICD-10 will likely be transparent to beneficiaries, but denied claims are expected to increase resulting in questions by beneficiaries. PRG, in conjunction with PCG serve as the conduit to timely communication to providers on behalf of beneficiaries.

The direct cost impact of the transition to ICD-10 will be close to zero. The cost to provide ICD-10 communications is ***minor*** as PRG foresees the development of communication materials a part of their regular workload. In addition, PRG does not foresee a need for special ICD-10 training at this time.

Strategic Research & Campaign Management Group (SRCMG)

The Strategic Research & Campaign Management Group (SRCMG) of the Office of External Affairs (OEA) develops communication strategies and implements communication campaigns in order to perform beneficiary education and outreach. The group provides direction to State and local programs assisting beneficiaries with maximizing their program benefits. SRCMG works in collaboration with other groups in OEA (Medicare Ombudsman Group, Partner Relations Group and Intergovernmental Relations Group) and the Regional Offices (ROs) to manage the State Health Insurance Program (SHIP) grant program. The group does not use ICD-9 codes in their processes; SRCMG focuses on education and outreach. SRCMG does not anticipate future messaging to beneficiaries about a transition to ICD-10 because the transition is expected to be transparent to beneficiaries. SRCMG does anticipate proactive communication and high-level training for the SHIPs about the ICD-10 codes as SHIPs work with beneficiaries to handle claims and billing issues.

Processes Identified

The following processes were identified and will have a ***minor*** impact from the transition to ICD-10.

Assist SHIPs with Resolving Beneficiary Inquiries

Of the three SRCMG divisions, only the Division of SHIP Relations (DSR) will be impacted by a transition to ICD-10. DSR coordinates State and local benefit education for Medicare beneficiaries. Although the day-to-day business activities making up this process were not defined, DSR identified a possible need to inform SHIPs about the transition to ICD-10, as SHIPs may need to prepare for an increase in beneficiary inquiries. DSR may also want to provide SHIPs with information materials to assist SHIPs with responding to beneficiary inquiries related to the transition. Informative materials may include Fact Sheets, FAQs (Frequently Asked Questions), links to **CMS websites**, and information provided through DSR's **SHIP Resource Center.** Lastly, SHIPs may request additional funding if they experience a significant increase in related beneficiary inquiries. DSR may need to develop an action plan that considers increased funding for SHIPs.

Impact: Overall, the Group agreed a transition to ICD-10 would have a ***minor*** affect on this process. However, if additional SHIP funding is required, the impact to this process may be elevated to ***modest***.

In beginning phases of the ICD-10 implementation, denied claims are expected to increase resulting in an increase in beneficiary calls **to state and local SHIPs**. SRCMG will need to develop a fact sheet for SHIPs to accurately assist callers. SHIPs will need to be made aware of the transition so they can prepare for the potential increase in call volume. SRCMG may communicate the upcoming change by placing phone calls to the Directors of the 54 SHIP programs and posting information to the website. In addition, **staff** at the SHIPs would need to be educated on the changes. Because SRCMG deals with grants and not competitive contracts, grants would not be affected. Transitioning to ICD-10 presents ***minor*** risks to SRCMG. However, if additional SHIP funding is required, the impact to this process may be elevated to ***modest***.

We believe the transition to ICD-10 would have next to no cost effect on this group (barring the highly unlikely possibility the transition proceeds so badly beneficiaries are affected in large numbers – in which case the cost impact on this group would still be ***minor***). However, if additional SHIP funding is required, the costs to this process may be elevated to ***modest***[79].

Tribal Affairs Group (TAG)

The Tribal Affairs Group (TAG) of the Office of External Affairs (OEA) provides consultation and support to CMS components for all activities related to American Indian/Alaska Native (AI/AN) health. TAG participates in policy analysis, consultation, and strategies for information dissemination and communicates with tribes and tribal representatives, Federal Agencies, national organizations and groups, and State and local governments in maters pertaining to AI/AN health.

[79] A Modest or Yellow Level Process with costs between $1,000,000 and $10,000,000..

Processes Identified

The following processes were identified and will have a minor impact from the transition to ICD-10.

Provide ICD Coding Training

TAG works with the Indian Health Services (IHS) to provide support to the IHS medical facilities caring for Native American Medicare beneficiaries. In the past, TAG has planned and funded ICD coding training for IHS facility coding staff. However, TAG is not currently budgeted to fund continued ICD code training. To assist the IHS facilities with a successful transition to ICD-10, the group may consider obtaining new funds to reinstate the IHS facility staff training.

Impact:
Unless TAG obtains additional funds for training, the impact of transitioning to ICD-10 for this process is ***minor*****,** as the group no longer funds an ICD training plan. If additional funding is obtained, the impact to this process may be elevated to ***modest***. The budget for providing coding training has decreased in recent years, and currently there are no funds in the budget for coding training. This responsibility has not been reassigned to another component; it has been phased out. TAG will communicate with IHS to begin discussing plans for training. IHS has conducted ICD-9 training in the past. It is not known if IHS would include Tribal facilities in future training requests.

Resolve Billing Issues

The process for resolving billing issues was not defined, even though TAG provides consultative services. Additional information is necessary to fully analyze the impact. However, TAG's work in resolving billing issues may increase if the transition to ICD-10 causes additional billing issues for IHS facilities. IHS and Tribal facilities are bound by Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations for standard code sets and are not exempt. IHS performs billing via electronic bill.

Impact:
The Group agreed a transition to ICD-10 would have a ***minor*** affect on the process for resolving billing issues, but it was undetermined how many claim rejections occur based on ICD-9 codes.

Obtain Data from Medicare Administrative Contractor

The process for obtaining and utilizing ICD-9 data was not defined. However, the Medicare Administrative Contractor (MAC) managing Indian Health claims (Trailblazers) is populating a data repository to collect information specifically for this population. The repository includes ICD-9 data which has been collected for the past ten years. The data repository will reportedly be available in nine to twelve months. The Medicare contractor will need to be informed of the

transition and have ample time to complete system updates in order to assure the integrity of ICD data stored in the repository. The group does not have processes or systems which rely on the data stored at Trailblazers.

Impact:
Therefore, a transition to ICD-10 will have a ***minor*** affect on data to be obtained from the MAC.

There are approximately 500 coders employed at Indian Health Services and 750-800 at Tribal facilities. All coders (and others using coded data) will need extensive coding training on the ICD-10-CM and ICD-10-PCS systems. IHS and Tribal facility claims may be coded incorrectly if ICD-10 coding training is not sufficiently provided to coding staff. Incorrect coding will lead to an increase in denied claims and inaccurate data, which will result in an increase in outstanding claims issues. This may also increase the number of billing issues requiring additional TAG consultations. Currently, the number of claims/beneficiaries involved is unknown, but estimates are 519,655 Part B claims in 2006 and 660,374 Part A claims for 2006.

Although a timeframe was not identified, TAG determined it will begin to communicate soon with IHS and Tribal facilities about coding training to develop a training plan. A number of issues will require resolution for the ICD-10 transition:

1. Who will do the training?
2. How will training be provided?
3. How many coders need to be trained?

Additionally, TAG will discuss systems requirements with IHS and Tribal facilities to accommodate the new ICD-10 code set which utilizes an expanded field size (from five to at least seven alphanumeric characters). Modification to current systems may be needed to account for the expanded ICD-10 fields. The group also identified an Executive Order mandating CMS to consult with Tribes and IHS when there is a potential program change with a significant impact on the Tribes or IHS. In these consultations, tribal organizations may request funding from CMS in order to assist them with the cost of becoming compliant with the program changes. TAG needs to begin this dialogue regarding systems updates and training related to the implementation to ICD-10 as soon as possible. Although coding training is not currently in the TAG budget, TAG may need to request additional funding. If training becomes a responsibility for TAG, the group will need to project costs based on the numbers of coders to be trained and the time required to complete training. TAG advocates face-to-face training, but has used Medicine Dish Broadcasts in the past. Note: In the American Hospital Association (AHA)/American Health Information Management Association (AHIMA) field test (ICD-10-CM only) 60% of participants felt 16 hours of training or less would be required, while 24% felt 17-24 hours of training was needed. A majority of participates (76.6%) indicated face-to-face training was preferable and intense training should occur 3-6 months prior to implementation (87.6%).

The exact risk to TAG is unknown at this time. In the current state, TAG performs in a consultative role, and the estimated risk may be ***minor***. If TAG assumes the responsibility for coding training or systems requirements, the risk could escalate to ***modest***[80] or higher.

Currently TAG provides consultation to IHS on billing issues. Billing issues may increase in the transition to ICD-10, additional consultation requests may occur, equating to additional work for TAG, resulting in ***minor*** risk. If individual IHS/Tribal facilities do not prepare adequately for the transition (in systems updates and coder training), the risk level may increase.

The transition to ICD-10 will involve a high risk to IHS/Tribal facilities. The main areas will involve coding training and systems update, but other risks will be involved. Even though these risks are related to the IHS/Tribal facilities directly, there consequences may indirectly affect TAG. As discussed previously, there will be an increase in billing issues, but if there is inadequate preparation, claims payment may cease altogether.

A process for updates to Trailblazer claims system was identified, however, the Trailblazer contract is held by the Center for Medicare Management (CMM). CMM Medicare Management Contractor Group (MCMG) Karen Jackson negotiates the contract. There is no risk identified to TAG in this process. TAG anticipates data may be available from the repository database in nine to twelve months, allowing TAG to begin statistical analysis/research. During the transition to ICD-10, there may be a ***minor*** risk to TAG if data is not available from Trailblazers. When TAG is able to retrieve data (based on claims data) from the repository, there will be data comparability issues after the transition. The structure and meanings of codes are different between the ICD-9 and ICD-10 systems; there is not an easy comparison between the data. Forward and backwards maps have been developed between the two systems (ICD-9 – ICD-10) and detailed analysis would need to be done between the two coding systems to interpret the data.

If OEA/TAG provides training for coders in the IHS system, the cost will be ***modest***. If no training were provided, the cost would be ***minor*** due to a potential increase in efforts to resolve billing issues. Additional modest costs would also be incurred in updating the Trailblazer claims system to accommodate ICD-10, but these costs would be paid for by CMM not OEA/TAG.

Office of E-Health Standards and Services (OESS)

The Office of E-Health Standards and Services (OESS) are responsible for developing and coordinating the Notice for Proposed Rule Making (NPRM) for the Modification to Medical Data Code Set Standards to Adopt CD–10–CM and ICD–10–PCS as well as for Health Insurance Portability and Accountability Act (HIPAA) 5010. Their responsibility includes:

[80] A Modest or Yellow Level Process risk will continue with intermittent modifications to the process.

coordinating the development of the NPRM, development of regulations and guidance materials, coordination and resolution of comments from internal CMS components, OMB and the public, development and implementation of associated enforcement programs, as well as outreach programs as it pertains to the particular NPRM.

OESS is also responsible for e-health strategies for CMS including the development and implementation of technical activities related to e-health services, as well as ensuring that individual activities tie to the agency and Federal e-health goals and strategies. OESS collaborates with HHS on policy issues related to e-health standards, serves as the central point of contact for the Office of the National Coordinator for Health Information Technology (ONCHIT), oversees the development of privacy and confidentiality policies pertaining to the collection, use, and release of individually identifiable data along with adopting and maintaining messaging and vocabulary standards supporting electronic prescribing under Medicare Part D.

Processes Identified

The following process was identified and will have a ***minor*** impact from the transition to ICD-10.

Develop and Facilitate the ICD-10-CM/PCS NPRM

The process for publishing an NPRM final rule starts with the development and coordination of the NPRM. This includes working with and getting input from subject matter experts to develop the initial draft NPRM. Once this coordination is complete the NPRM written, it must be approved by the Federal government. There are three approvals that must be gained.

1. *The HHS Data Council's Committee on Health Data Standards*. This Committee is responsible for overseeing the entire AS implementation process for the Secretary of HHS. This Committee, composed of members from many Federal agencies, must approve the content of the NPRM before they go to the next review step.

2. *Advisors to the Secretary within HHS*. HHS consists of several divisions that may be affected by the proposed standards or that are responsible for particular issues, such as the impact of the standards on the Federal budget. Agency heads also act as formal advisors to the Secretary of HHS in the rule making process. Agreement among the Secretary's advisors must be reached before the NPRM go to the next review step.

3. *The Office of Management and Budget*. OMB reviews the NPRM from a government-wide perspective and circulates the NPRM for review by Federal departments other than HHS. These departments, which will also be affected by the proposed standards, include the Departments of Defense and Veterans Affairs. In addition, OMB reviews the NPRM for their potential impacts -- e.g., on the Federal budget, on intergovernmental relations, and on small business -- and for their compliance with the principles of regulation set out in Executive Order 12866.

Publication of a proposed regulation in the Federal Register begins the next phase of formal public participation in rule making. The following steps occur prior to publication of the final rule

1. *Publication of Proposed Rule*. A Notice of Proposed Rule Making (NPRM) is published in the Federal Register and on the Administrative Simplification Home Page.

2. *Comment Period.* Each NPRM is followed by a period set aside for public comment. Comments will be accepted through this website and by postal mail for 60 days following publication. The purpose of the comment period is to provide an opportunity for the public and interested and affected parties to influence the outcome by raising issues and questions that can be addressed before the regulation is finalized.

3. *Public Inspection of Comments.* Comments received are made available for public inspection. Traditionally, comments submitted by mail are available for public viewing in a room at HHS Headquarters in Washington, DC. Comments will be available for public viewing at this website after the comment period has ended.

4. *Analysis of Comments.* Comments are analyzed and summarized, and responses are prepared by the Implementation Teams responsible for the content.

5. *Publication of Final Rule.* The Final Rule is published in the Federal Register and on the administrative Simplification Home Page. The Final Rule includes a summary of the comments and responses to the comments, including any changes that were made to the proposed regulation as a result of the comments.

Impact: Overall, OESS agreed a transition to ICD-10 would have a ***minor*** impact on this process due to increased workload in getting the NPRM to final rule.

Office of Financial Management (OFM)

Accounting Management Group (AMG)

AMG is responsible for the accounting functions for CMS, including debt settlement, contractor financial oversight, internal and external reporting, and preparation of CMS' financial statements.

Accounting Management Group is responsible for the overall Accounting function for CMS. AMG responsibilities are mostly related to financial reporting and to payment and debt settlement activities for Medicare providers or plans and Medicaid programs and contractors. To complete these activities, AMG processes and systems do not utilize ICD-9 coded data. The data AMG uses is summary level information focused on payment.

AMG utilizes data from Eligibility and Entitlement Database (EDB) and uses the Contractor Administrator Financial Management (CAFM) system to support its activities. These two

systems contain ICD-9 coded data. However, in both cases, AMG does not use or access ICD-9 coded data in these systems. The information AMG systematically obtained from EDB does not contain ICD codes and AMG's use of CAFM is for financial purposes and is not related to claims level information.

Processes Identified

There were no specific processes or systems identified and this assessment is for the group as a whole.

Impact

The impact of ICD-10 implementation for this group is ***minor***.

Budget Analysis Group (BAG)

The Budget and Analysis Group (BAG) within the Office of Financial Management (OFM) is responsible for the development of the Agency's budget in accordance with the Agency's strategic plan and the Government Performance and Results Act (GPRA). The process involves working across the Agency providing advice and assistance to other CMS components in the development of budget justification materials. This group also has oversight responsibility of the Program Assessment Rating Tool (PART) program mandated by the Office of Management and Budget to assess the performance of all federal programs.

BAG is responsible for working across the Agency and formulating the budget, including consulting on appropriation issues and developing budget estimates, oversight of the Contractor Reporting Workload of Data (CROWD) system, coordination and development of the annual GPRA report, and the execution side of the budget which involves putting together an operational plan based on secured funding.

Processes Identified

The following process was identified and will have a ***minor*** impact.

- Government Performance Results Act

The BAG is responsible for the process of reporting CMS' Government Performance Results Act (GPRA) goals. GPRA goals, by law, are reported to the Office of Management and Budget (OMB) on a yearly basis. The BAG is also responsible for providing an internal quarterly GPRA update to CMS staff. Of the approximately 30 GPRA goals CMS must address, there are six goals that are either indirectly or directly tied to ICD-9 codes. These clinical quality goals include such activities as chart review and trend analysis. The BAG itself does not develop the metrics for these clinical quality goals. Other components within CMS develop these metrics, using claims data and ICD-9 codes and then forward the synthesized metrics to the BAG for GPRA reporting.

Impact

The impact to the BAG with the transition to ICD-10 will be ***minor***. The development of the metrics, which rely on claims data and corresponding ICD-9 codes, needed to create the GPRA clinical quality goals falls under the responsibility of other components within CMS. The BAG is solely responsible for gathering the data and developing the GPRA report. If delays in the transition to ICD-10 impacted claims data or processing, the BAG may not receive clinical quality goals data. A delay would potentially lead to the incomplete reporting of GPRA goals. The failure to provide complete GPRA goals due to the transition to ICD-10 would pose a minor impact to the BAG. Additionally, program experts from the components will need to notify the BAG if any changes were made to the methods of data collection, for clinical quality metrics, resulting from the transition to ICD-10.

Potential Risk

The assessed level of risk to this process is ***minor***. The BAG is at risk, if the transition from ICD-9 to ICD-10 does not go smoothly, of providing incomplete GPRA goals. The BAG would need to include in their GPRA report that clinical quality data were delayed and unable to be processed due to the transition from ICD-9 to ICD-10.

Cost Implications

We believe the transition to ICD-10 will have ***minor*** cost implications to the BAG. The BAG is solely responsible for the development of the GPRA report and relies on other components within CMS to supply the clinical quality data. As the BAG has standard processes to address incomplete or missing data in their GPRA reports, the transition to ICD-10 will impose minor additional costs to this group.

Financial Services Group (FSG)

We met with the Office of Financial Management (OFM), Financial Services Group (FSG) to discuss the Recovery Audit Process and the new national roll out of the Recovery Audit program. The CMS' current processes and systems in place to support the Recovery Audit Contractors (RACs) will have no impact from the transition to ICD-10 codes. RACs are paid on a contingency basis by CMS, based on the incorrect payments they identify. Any impacts on the RACs processes or systems would be the responsibility of the RACs, not CMS.

Processes Identified

There were no processes or systems that will be impacted by the transition to ICD-10.

The Office of Legislation (OL)

All Medicare legislative initiatives and issues including drafting of healthcare legislation and policy are the responsibility of the Office of Legislation (OL). Primary functions within OL are

developing and communicating the President's legislative agenda, providing technical assistance and corresponding with Congress in regards to the legislative agenda, and presenting the positions of the agency in formal Congressional hearing functions.

The three analytic groups for Medicare: Parts A & B; C & D; and Low Income Analysis Groups (Medicaid) each work as the primary liaison for CMS in regards to legislative issues with the Congressional authorizing committees having jurisdiction over Medicare. Responsibilities include arranging or preparing Congressional briefings and responding to inquiries in response to healthcare legislation or mandates regarding these particular areas within the agency. The groups collaborate and work closely with subject matter experts within the Centers for Medicare Management, Centers for Beneficiary Choices, and Centers for Medicaid and State Operations.

The Congressional Affairs Group within OL deals with the constituent concerns brought forth by individual members of Congress.

The Hearings & Policy Presentation Group presents CMS' position on any specific healthcare topic being presented at hearings on behalf of the agency or department.

Processes Identified

The following process was identified and will have a minor impact from the ICD-10 transition:

- Assists CMS components in drafting healthcare legislation
- Responds to Congressional group and constituent inquiries
- Presents the administration's position on healthcare legislative topics before Congress

The Medicare Part A & B Analytics Group within OL is the liaison for the agency in regards to legislative proposals for fee-for-service issues with Congressional authorizing committees that have jurisdiction over Medicare. Once ICD-10 is implemented, any Congressional inquiries or briefings associated with CMS' progress would require interaction with this particular group. Past legislative proposals regarding health information technology (HIT) have previously introduced the ICD-10 issue to the Part A & B Analytics Group.

The implementation of 5010 transaction standards will not support the ICD-10 code set. The 5010 version of the electronic transaction standards provide standards, which include ICD-10 code sets, for the collection and transmission of health data. Any delays in implementing the new versions of the 5010 transaction standards will further delay implementation of the new ICD-10 code sets. The Part A & B Analytics Group has a pending Congressional briefing request on 5010 transactions standards. If approved, the briefing request will require technical assistance from CMS subject matter expert components to align the draft legislation to help achieve CMS objectives.

In response to Congressional inquiries regarding ICD-10, the Part A & B Analytics Group works with Center for Medicare Management (CMM) subject matter experts for development of inquiry responses or preparations for more formal briefings are needed. Once the agency

moves forward with ICD-10, the primary focus of the Analytics Group would be to communicate and promote the known benefits of ICD-10 implementation.

The emphasis of the Congressional Affairs Group is focused more on individual constituent concerns and responds to individual Congressional member inquiries and issues regarding ICD-10 policy.

The Hearings Group presents the administration's position on healthcare legislative topics. Once an agency designee is appointed to testify before Congress on ICD-10, the Hearings Group will help prepare the witness, write testimony, guide the process and coach the witness.

Impact:
OL has a predicted ***minor*** or no impact to processes during the transition to ICD-10.

Office of Operations Management (OOM)

The Office of Operations Management (OOM) groups interviewed were: Administrative Services Group, Planning, Performance Management and Analysis Group and Office of Hearings.

The ICD-10 planning project concluded its first phase in September, 2008. In April we interviewed Marty and two other OOM staff from ASG and PMAG to discuss potential impacts of ICD-10 to OOM's process and systems – we determined after that one hour meeting that there would no direct impact to OOM and therefore did not pursue discussions any further. After assessing the entire agency, we developed a report that discusses what parts of CMS (processes and systems) will be impacted by a transition to ICD-10. It is an initial assessment and since we have started phase 2 which will develop it further. OOM is mentioned in the last chapter of the 300 page report as one of the areas in CMS that will not be impacted.

Processes Identified:

There were no processes or systems identified impacted by the implementation of ICD-10.

Impact

The implementation of ICD-10 will have a ***minor*** impact on the interviewed groups as OOM does not work with ICD-9 codes or DRG level data.

Office of Strategic Operations and Regulatory Affairs (OSORA)

Audit, Analysis and Information Group (AAIG)

The Audit, Analysis and Information Group (AAIG) within the Office of Strategic Operations and Regulatory Affairs (OSORA) is responsible for the coordination of internal Agency's communications.

Processes Identified

AAIG serves as the audit liaison to the Government Accountability Office (GAO) and the Health and Human Services Office of Inspector General (OIG). This process involves the receipt of the audit request from either GAO or OIG and the coordination with the appropriate CMS component to obtain a response to the audit request. All data requests from either the GAO or OIG are also processed through the DAL. The DAL utilizes the Audits Tracking and Reporting System (ATARS) to track and report the audit resolution process for all GAO and OIG audit requests. AAIG also has the responsibility of serving as the liaison with the Small Business Administrator's office of the National Ombudsman. This process begins by receiving a complaint from a small business. AAIG then collaborates with the appropriate CMS component to bring about satisfactory resolution of the complaint. The oversight of information technology for all of OSORA's business systems is another function of the AAIG as well as responsibility of the various OSORA systems which track regulation processes, audit report processes, correspondence processes, manual instructions, Freedom of Information Act (FOIA) and OSORA's Reports to Congress.

Processes Identified

The following was identified and will have no impact from the ICD-10 transition.

AAIG processes do not utilize ICD-9 codes; therefore the transition to ICD-10 will have no impact on AAIG's current processes.

Freedom of Information Group (FIG)

Processes Identified

The following process was identified and is expected to have a ***minor*** impact from the ICD-10 transition.

Response to Freedom of Information Act (FOIA) Requests with Electronic Data

If the system storing the requested electronic data or the data quality is affected by the transition, the data may not be readily available. Overall, the implementation of ICD-10 will have a ***minor*** impact on FIG processes and systems.

Impact

No ICD-9 coded data is utilized by this group, however, if the system providing electronic data for a FOIA request is negatively affected by the transition to ICD-10, there may be a delay in the data received by FIG or data may not be able to be retrieved, at all. The system may not be available to provide the requested data or the data quality may be impacted. This could result in either a delay in sending the response to the requestor or in FIG not being able to fulfill request.

Risk Identified

Based on FIG interview and additional analysis, the implementation of ICD-10 will be ***minor*** risk to the FIG.

If systems providing data are negatively affected by the transition to ICD-10, this may delay or prohibit a component's ability to provide the data requested. There is a requirement in FOIA for FIG to reply to freedom of information requests within 20 business days from receipt of request. Any delays in retrieving data may prevent FIG from meeting this requirement. If data cannot to provided, at all, and FIG is not able to respond to the request, the requestor has the option to file a lawsuit against CMS to obtain the records. While this would create additional work for FIG staff, FIG's existing processes would not be affected.

Issuances and Records Management Group (IMG)

Processes Identified

The following process were identified and are expected to have minor impact due to the transition to ICD-10.

Issuances Process

IRMG is responsible for issuing policy instructions to various stakeholders, such as Medicare contractors, state agencies and Part D managed care organizations. This process begins when IRMG receives a policy instruction, including change requests. IRMG forwards the policy instructions to Office of Management and Budget (OMB) for their review and approval. Once IRMG receives OMB's approval they issue the policy instructions to the various stakeholders. Additionally, IRMG is responsible for updates to the Internet Only Manuals during this issuance process.

Vital Records Process

IRMG is responsible for the establishment of a tiered ranking for the order in which the Agency's records would be restored in the event of a disaster.

Records Management Process

IRMG is responsible for the process of scheduling all of the Agency's records, including systems, with the National Archives and Records Administration. Scheduling is an administrative process to assure records are protected and retained for the appropriate time frame. The IRMG records manager works with CMS components identifying records and systems that require scheduling. The actual documentation required in the schedule is completed by the appropriate component, forwarded to the records manager who forwards to

the National Archives and Records Administration for approval. ICD-10 and the Diagnostic Related Groups (DRGs) are considered to be Agency records and will be required to go through the scheduling process.

Impact: The impact to the IRMG with the transition to ICD-10 will be ***minor***. ICD-10 and DRGs will need to go through the records management process, however, scheduling these would be no different than the normal process currently performed by the records manager. Additionally, the volume of work involved with the processing of policy instructions and updates to the Internet Online Manuals will increase due to the transition, however it was noted that this will not pose a significant impact to IRMG.

Initial Identified Risk Assessment

There are no identifiable risks to the IRMG due to the transition to ICD-10.

Initial Identified Cost Implications

We estimate that there would be no costs associated with the transition to ICD-10 for the IRMG.