The concept of neutrality risk management is of particular concern for payers and providers as the U.S. moves to adopt a new standard for coding diagnoses and inpatient procedures based on the International Classification of Diseases, Tenth Revision (ICD-10) code standards. ICD-10 only applies to diagnoses and provides no methodology for classifying medical treatments. To ensure that the new ICD-10 code set meets the requirements of the health care industry, the United States has modified the basic ICD-10 standard to include clinical modifications that add granularity to diagnosis coding (ICD-10-CM) and created a procedural classification system (ICD-10-PCS) that specifies codes to be used for clinical procedures performed on inpatient populations. Because of these changes, the United States does not have sufficient experience to draw from internationally to establish a clear roadmap for neutrality risk management with the transition to ICD-10.

Neutrality risk management is often thought of strictly in financial terms. With ICD-10 for example, payers will see no impact to their revenue, reimbursement, and medical loss ratio (MLR) after the conversion to ICD-10 and providers will see no loss in reimbursement after the transition. This narrow interpretation of neutrality risk management is not entirely attainable due to the many variables that will affect revenue and reimbursement. The transition from the current code set ICD-9 to ICD-10 has substantial financial and operational implications for the entire health services industry and every aspect of business operations. For health plans, this will require significant changes in business functions and information technology (IT) infrastructure that are necessary to mitigate neutrality risk. Health plans must start now to establish a framework for preparation and provide a strategy for measuring and managing the transition to ICD-10 that helps to successfully remedy potential losses. Specific tasks are required to accurately assess the three areas of neutrality across the enterprise, develop and implement an effective plan, and achieve meaningful changes that support a successful transition.
Background on ICD-10 neutrality risk management

Begin by considering three categories of neutrality risk and its implications:

- Medical payment predictability
- Clinical integrity
- Operational stability

Because the conversion to ICD-10 has operational and financial implications that go beyond the costs of achieving regulatory compliance, the transition to ICD-10 will have a profound affect on all aspects of payer operations including:

- Technology
- Claims operations
- Call center operations
- Provider relations
- Provider contracting
- Financial performance and reimbursement
- Post payment audit and recovery
- Medical management

ICD-10 impacts across the functional areas

ICD-10 is not simply a refinement or expansion of ICD-9, rather, it represents a wholesale replacement of one coding system with another that is fundamentally different in terms of structure and logic. For this reason, the introduction of ICD-10-CM/PCS requires a massive overhaul of the U.S. systems used to manage and pay for health services. The capacity of health care organizations to meet the clinical needs of the populations they serve will depend upon their ability to manage the transition to ICD-10 effectively.

The transition to ICD-10-CM/PCS will be especially important for inpatient hospital services that are reimbursed using some form of diagnosis related groups (DRGs). ICD-10-PCS, which will be used primarily to describe procedures performed on an inpatient basis, differs radically from the ICD-9-CM coding paradigm. This stands in contrast to ICD-9-CM and ICD-10-CM diagnosis codes, which differ more in terms of granularity rather than coding logic. However, some outpatient contracts will also be affected because of the role diagnostic information plays in determining outpatient reimbursement through claims editing, medical policies, and certain types of payment methodologies such as enhanced ambulatory patient groups (EAPGs). The uncertainty on facility coding will also have an impact on neutrality risk.

The following sections discuss the three areas of neutrality risk, the business functions associated with each area, and the variables influencing risk management. Accurate evaluation of risk management should consider measures of:

- Current state
- Transitional state
- Steady state

Effective planning and execution of measuring, monitoring, and mitigating defects can facilitate a successful transition and establish an earlier stable and steady state for all aspects of operations.
Medical cost predictability

Medical cost predictability (MCP) defines the range of potential change in reimbursement to providers and remediates contributing variables that can lead to decreased variability (reimbursement predictability). Also considered in this area are:

- **Benefit neutrality:** in which there are no unintended adverse impact for members on benefits or co-pays of deductibles
- **Revenue predictability:** Medicare plans will not see changes in revenue based on changes to hierarchical condition code (HCC) scores and encounter data reporting will continue for state health plans

Financial performance, post-payment audit and recovery, and provider contracting and technology (in claims edits) are all areas that are both affected by and influence MCP. To measure and mitigate MCP, a health plan needs to first complete their mapping of codes from ICD-9 to ICD-10 in order to better understand the potential changes in DRG assignment that will result. Following the initial mapping effort, a financial impact analysis can be conducted to provide a range of payment possibilities based on shifts in DRGs and identify areas of greatest risk.

Based upon that financial analysis, health plans can consider changes to provider contracts and medical policies and identify areas where variance can be reduced. However, as providers begin to code cases in ICD-10, reimbursement may change for specific cases even in the absence of changes in clinical behavior because claim edits and medical policies may be interpreted differently. The integrity of data assets developed over time will be compromised by changes in coding and the differences in provider’s success in adopting the ICD-10 code set. The increased granularity of diagnostic codes allows for legitimate decisions by the providers to code to a reimbursement group that may have a higher reimbursement than was available in the ICD-9 code set. In addition, revisions to provider contracts incorporating changes in contract language based on ICD-10 codes and their interpretation will be required. While complete financial neutrality may not be possible, projecting the expected range in reimbursement can allow a health plan to make prudent plans with their reserves. Once systems and business functions are remediated, test scenarios will need to be developed in order to execute end-to-end testing and measure any potential variance to covered benefits, co-pays, and deductibles. This will allow the plan to execute mitigating strategies that will preserve financial stability for covered members. Similarly, test scenarios will help to determine if there is any reimbursement variance based on HCC scores or encounter data reporting which will be necessary to evaluate and refine revenue predictability for health plans.

Throughout ICD-10 remediation, key performance measures need to reviewed and managed and those responsible need to have clearly established metrics for MCP that reflects the current state. They need to establish an approach and environment for measuring variance in the transitional state (with a new proposed deadline of October 1, 2014). And finally, they will need to define clear methodologies for measuring results and changes in fraud, waste, and abuse detection and payment accuracy. The health plan will continue to apply system, contract, and policy mitigation strategies for at least six to nine months after the transition to ICD-10 in order to achieve a steady state in all aspects of financial performance.

Clinical integrity

Clinical integrity refers to making sure that the population management activities and medical policies within a health plan continue as intended following the conversion. Specifically, the medical management activities that are potentially affected include:

- **Authorization and notification**—those services and conditions that require prior / concurrent authorization or notification on September 2014, will continue to be identified for this function
- **Utilization management (UM)**—those services and conditions that a health plan seeks to engage in UM activities will continue to be identified for UM
- **Bridges to care programs (post-hospital follow up)**—high-risk conditions can be identified for effective outreach, case management, and health care navigation prior to discharge or shortly thereafter
- **Complex case management (CCM)**—outpatient conditions requiring concurrent case management support are effectively selected from data following the transition to ICD-10
- **Disease management (DM)**—strategies for identification and stratification for selection for DM programs will remain consistent with health plan
- **HEDIS Reporting, STARS ratings, and accreditation documentation**—data elements supporting these elements are captured without gaps and can effectively measure historical trends

ICD-10-CM also changes diagnostic coding processes. The ICD-10 codes, which align with corresponding CPT® codes, are elements critical for many of the above activities. Mapping ICD-10 to ICD-9 diagnostic codes is required to support clinical integrity. Test scenarios and end-to-end testing activities are required to reduce variance to achieving clinical integrity and assure that identification and stratification remains intact as intended by the health plan and medical management operations. Mapping to historical reporting will be essential for a number of activities.
Operational stability

Operational stability refers to the ability of a health plan to effectively predict operational changes to performance in claims operations, call center operations, and provider relations, and to develop mitigation plans to manage transitional impacts and return to a steady state. The top three operational issues include:

- A substantial period of time during which systems will need to accommodate both ICD-9-CM and ICD-10-CM/PCS codes. During the transition period that follows October 1, 2014, health plans will be receiving claims submissions that use both ICD-9-CM and ICD-10-CM/PCS codes, depending upon dates of service. Eventually, ICD-9-CM claims will become less common, but health plans will face an ongoing need to manage both claims sets simultaneously for provider relations, population risk assessment, fraud, waste, and abuse detection, and a variety of trend analytics.

- There is no simple way to map between ICD-9-CM and ICD-10-CM/PCS. The two code sets are sufficiently different that most translation schemes will truly involve many-to-many relationships.

- Providers will be in different stages of adoption and remediation for ICD-10 in their business operations and this will have a direct impact on call center operations, increased call volume should be expected.

Despite significant challenges, health plan operations will need to continue to hit all key performance indicators (KPI) and service level agreements (SLAs) for their commercial, state, and Medicare customers including:

- Claims processing turnaround time
- Claims payment accuracy
- Auto-adjudication rates
- Aging of claims
- Average speed to answer
- Call abandonment rates

In order to successfully sustain performance on KPIs and SLAs, health plans must plan for mitigation efforts. These include effective training (assigning claims processing staff who can work on both ICD-9 and ICD-10 coded claims), additional call center staffing, development of useable job aids, manuals, and workflows, well-designed provider communication approaches, effective change management strategies for internal staff, and business intelligence and forecasting tools.

Conclusion

How health plans manage the risk of neutrality in the transition to ICD-10 in a way that delivers as much predictability as possible to its internal and external stakeholders is key to a successful conversion. Organizations can take advantage of the improved information that will be available under the ICD-10 standard by initiating a systematic, organized, and sustained effort to deploy ICD-10 across their enterprise and to integrate the new system into its core business functions. Neutrality risk management can be enhanced with careful planning and access to industry leading tools, information, and consulting leadership. The health plans that prepare for these changes early and measure often can reduce variance in medical cost predictability, clinical integrity, and operational stability.
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