CMS' Agency-Wide ICD-10 Program and Activities to Date

Presentation to the NCVHS Subcommittee on Standards

Todd Couts (Noblis)

CMS ICD-10 PMO

June 17, 2011

Agenda

- CMS' ICD-10 Roles
- Update on CMS' Medicare ICD-10 Implementation

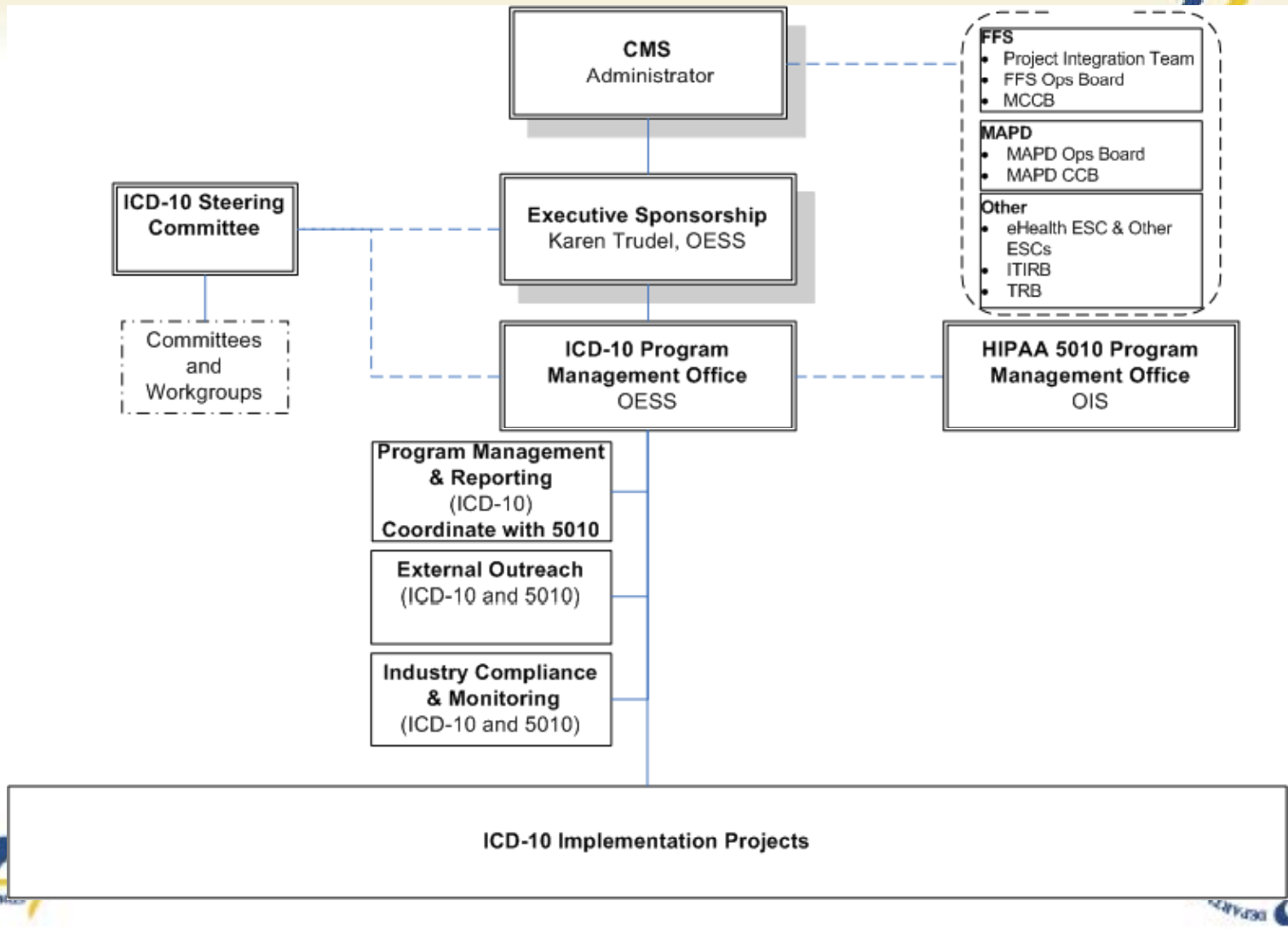
CMS' ICD-10 Roles

- **ICD-10 Rulemaking**
- **Medicare and Medicaid**
  - Manage and execute Medicare ICD-10 implementation
  - Oversight and Technical Assistance for State Medicaid Implementations
- **Industry**
  - Compliance Monitoring, Outreach, and Education
  - Tools – GEM and Reimbursement Mapping
  - Procedure Coding System Maintainer

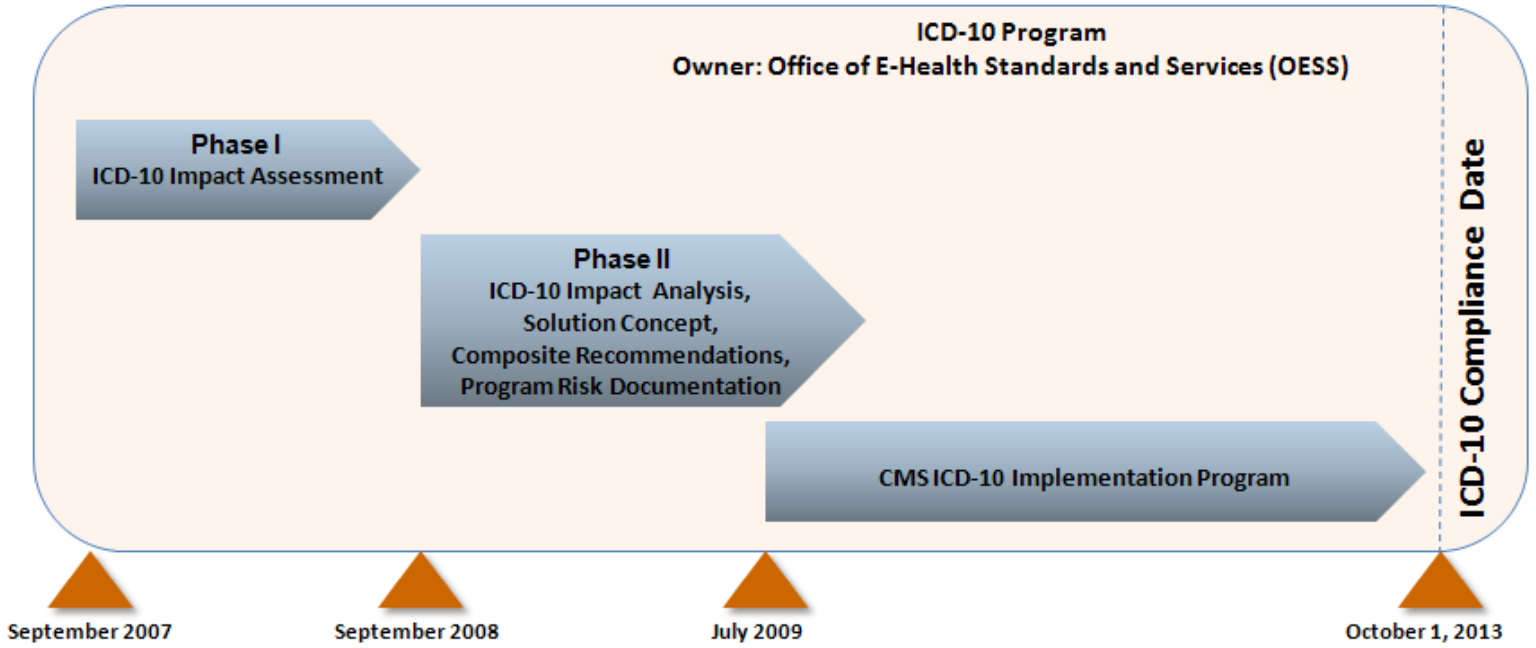
Medicare Implementation Activities-To-Date

- **Governance**
  - Established cross functional Steering Committee
  - Program Management Office (PMO) established
  - Project Areas defined with leads and teams
- **Impact Analysis**
  - Agency Wide Impact Analysis (http://www.cms.gov/ICD10/04_CMSImplementationPlanning.asp#TopOfPage)
  - Project Area Teams completed detailed impact analysis
- **Remediation / development activities**
  - Requirements and change request development in progress
  - Development progress in key areas

ICD-10 Program Organization



ICD-10 Program History and Current State

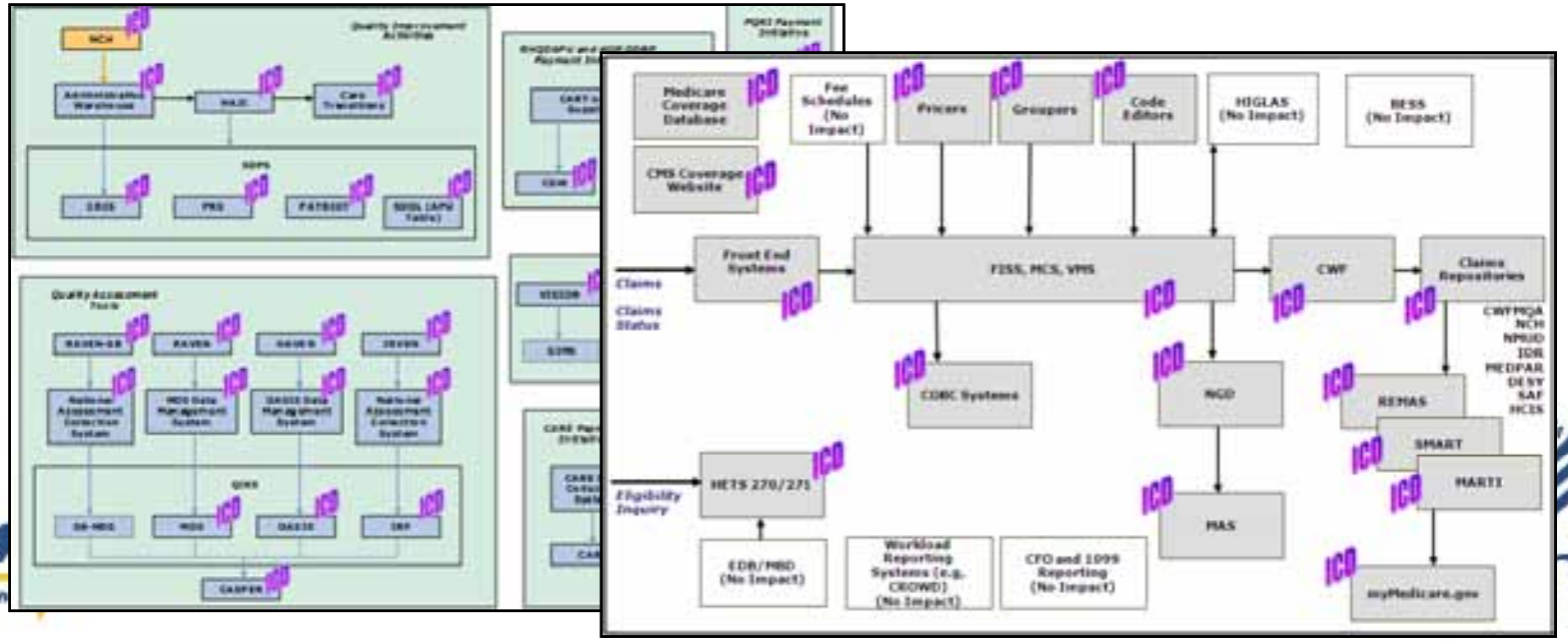


Impact Analysis

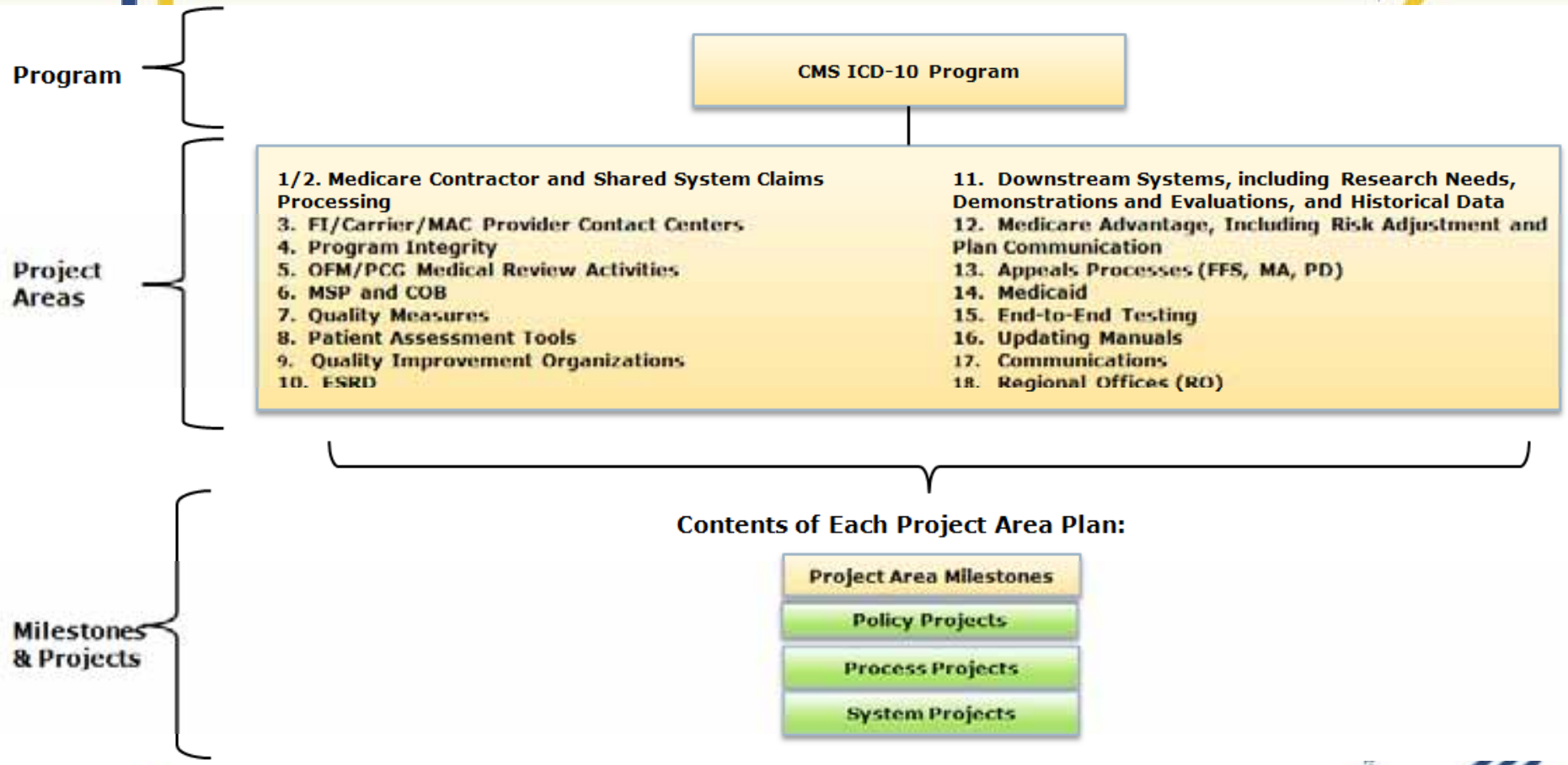
- **Major lines of CMS Medicare business are impacted**

1/2. Medicare Contractor and Shared System Claims Processing
3. FI/Carrier/MAC Provider Contact Centers
4. Program Integrity
5. OFM/PCG Medical Review Activities
6. MSP and COB
7. Quality Measures
8. Patient Assessment Tools
9. Quality Improvement Organizations
10. ESRD
11. Downstream Systems, including Research Needs, Demonstrations and Evaluations, and Historical Data
12. Medicare Advantage, Including Risk Adjustment and Plan Communication
13. Appeals Processes (FFS, MA, PD)
14. Medicaid
15. End-to-End Testing
16. Updating Manuals
17. Communications
18. Regional Offices (RO)

- **Over 70 IT Systems Impacted**



Project Structure



Implementation Strategy

- Upgrade Strategy
  - Changing policies, procedures, and IT systems to accept and utilize ICD-10 natively
- NOT pursuing a crosswalk strategy

FFS Claims Highlights

- ICD-based edits identified and categorized into six groups: National Coverage Decisions (NCDs), other national edits, Local Coverage Determinations (LCDs), other local edits, front-end edits, and obsolete edits.
- Developing national ICD-10 file with policy indicators
- Writing change requests to start Shared System changes in January 2012
- All change requests through October 2013 must include ICD-9 and ICD-10 requirements
- Medicare Severity Diagnosis Related Group (MS-DRG) updated for ICD-10
- Remaining Groupers, Pricer and Code Editor Updates in process

Other Highlights

- **Part C Risk Adjustment**
  - Updates to Hierarchical Condition Categories (HCC) and risk scoring in process
- **Coordination of Benefits (COB) / Medicare as a Secondary Payer (MSP)**
  - Strategy defined for ICD-9 to ICD-10 translation
- **Quality Programs**
  - Measure re-specification plans in process for the Quality Reporting Programs
  - ESRD CrownWeb changes identified and planned for December 2012
- **Strategy developed to update Medicare manuals**
- **Reviewing forms affected by ICD-10 and Paperwork Reduction Act (PRA) process implications**

June 17, 2011

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

Subcommittee on Standards

Industry implementation of updated and new HIPAA Standards and Code Sets

X12 Version 5010, NCPDP Version D.0

Comments from
VA Health Care as Health Care Provider
Department of Veterans Affairs

Good morning and thank you for the opportunity to make this presentation today.

These remarks address 3 of the suggested topics specific to the X12 Version 5010 and NCPDP Version D.0 implementation which are applicable to VA as a healthcare provider:

1. **VA Health Care's current state of implementation**
2. **Risk areas for industry compliance by the deadlines**
3. **Post Implementation concerns and mitigation strategies**

VA Health Care's current state of implementation

VA Health Care, as you know, is the country's largest integrated healthcare provider. About 10 million insurance claims a year are submitted for healthcare not related to veterans' military service. VA does business with about 1600 payers, of which 200 account for most of the claims.

VA prepared for 5010/D.0 by first conducting a gap analysis in March 2009. A governance board was then formed to oversee the system changes. The board organized those changes into several functional areas that would move through the software development lifecycle in a staggered approach. Of the seventeen functional areas identified for VA's system changes, about 25% is either in the requirements, design, or build phase. Another 25% is awaiting external testing. The remaining 50% of the required system changes have been completed and deployed nationally.

The remaining 5010/D.0 work considered most critical is testing with external parties. VA expects to conduct some external testing through front-end testing, defined as mapping and content validation testing with *individual* gateway partners, including clearinghouses and fiscal intermediaries. This will be followed by end-to-end testing, defined as full revenue cycle and integrated system testing with *all* its gateway partners and payers.

To date, VA has not made significant progress on either front-end or end-to-end testing with its various gateway partners. Since early 2010, VA has worked in a concerted effort with external gateway partners, establishing a bi-weekly industry trading partner call to ensure all interfacing organizations could effectively collaborate on timelines for testing. Despite this effort, only minimal testing has occurred with partners and has been limited to exchanging data files.

Testing with payers is also progressing slowly. For medical claims, VA has not yet tested with any payers. Outreach to payers for medical claims shows that the bulk of the payer testing will likely occur in late 2011 which is a significant risk. VA has been able to test with just one Pharmacy Benefit Manager (PBM) for primary pharmacy claims billing and has been unable to validate our secondary billing process at this time. Again, outreach to PBMs shows that most PBM testing will occur in late 2011.

Risk areas for industry compliance by the deadlines

The biggest 5010/D.0 compliance risk that VA is concerned with is *the ability to perform external end-to-end testing by Fall 2011*. End-to-end testing completed by Fall 2011 would allow for adequate time to address and resolve system issues before the compliance deadline.

End-to-end testing for VA is complex. VA medical claim transactions originate in our billing system and are transmitted through our internal gateway, then out to our clearinghouse, before reaching the payer or payer's fiscal intermediary. Similarly, inbound transactions travel the same path from the payer to our clearinghouse/lockbox bank, then through our internal gateway before being processed and payment posted in our collections system and ultimately our general ledger of accounts. VA must ensure that a minimum of eight touch points are

validated as a part of medical claims operational readiness testing. A slightly less complicated but similar process occurs with VA pharmacy claim transactions.

Thus far, VA has identified very few payers and PBMs where any end-to-end testing can be completed by Fall 2011. Our perception is that end-to-end testing will only be possible sometime after the Fall, causing serious risk that any identified issues will not be able to be resolved prior to the compliance deadline.

Post Implementation concerns and mitigation strategies

VA has identified various post implementation concerns and has several mitigation strategies in place.

Concerns

1. New rejections. VA has no history of managing any newly observed claim rejection codes that surface from 5010/D.0. Resolution of these new rejections will require additional resources, training, and time. It is a concern that new rejections could potentially result in lost revenue due to inadequate knowledge, or time needed to resolve new rejections.

2. Various payer systems. Testing can only go so far to validate the operational fitness of the system. Experience with the NPI implementation and 4010 shows that payers' systems tend to be different. Given the number of payers to which VA sends healthcare claims, it is impossible for us to test with all payers. Even successful testing in 2011 with a key group of payers doesn't necessarily predict success with all payers. As new payers migrate to 5010, it is a concern that additional system issues will be identified that will require system changes.

Mitigation Strategies

VA is employing several mitigation strategies based upon these concerns.

First, VA plans to retain active development resources through the first quarter of calendar year 2012 to address operational impacts to revenue systems as we migrate payers to the new standard. These resources can help address any additional system

changes that are identified with payers that were not part of VA's testing. Additionally, business subject matter experts (SMEs) will be retained to address trouble-shooting and problem-solving for areas such as new rejections.

Second, VA is targeting the most significant payers, based upon claim volume or dollar amount, to engage in testing before Fall 2011. Working out issues with significant payers before the compliance deadline will reduce serious impacts to the revenue stream.

Finally, this month, VA released an EDI Transactions Support internet site intended to facilitate testing and communication between VA, partners, and payers. The site is accessible by organizations outside of VA and presents status on VA's progress toward migrating its operation to the 5010/D.0 transaction standards. The site reflects VA's readiness for external testing and provides a direct contact to VA testing resources. The initial focus of the website content is the 5010/D.0 mandates but the site has been built to accommodate on-going EDI Transactions compliance mandates, such as EDI New Standards and Operating Rules.

Overall, in our view, there are significant risks to industry compliance by the 5010/D.0 deadline, and significant concern over the emergence of post implementation issues. In reality, given the current status of the implementation industry-wide, the likelihood that all transactions will be transitioned by January 1, 2012 is improbable.

I hope these remarks have been helpful, and I thank you for the opportunity to address this committee.

Indian Health Service
Update on HIPAA X12 Version 5010
NCPDP Version D.0 / 3.0
ICD-10

Janice M. Chase, RHIT
Practice Management /ICD-10 Lead
Indian Health Service
Office of Information Technology
June 17, 2011

Outline

- **IHS Overview**
  - **Resource & Patient Management System (RPMS)**
- **IHS Implementation**
  - **X12 Version 5010**
  - **NCPDP Version D.0**
  - **NCPDP Version 3.0** *(Not utilized)*
  - **ICD-10**
- **Summary of Key Challenges**

The Indian Health Care System

- Nearly 700 facilities in 35 states

	Federal	Tribal
Hospitals	29	16
Health Centers	59	237
Health Stations	28	93
Residential Treatment Centers	5	28
Alaska Village Clinics		166
Urban Programs	34	

IHS Health Information System

- Resource and Patient Management System (RPMS)
  - Comprehensive health information system
  - Clinical applications including EHR and ancillary services
  - Practice management applications including full revenue cycle
  - Panel and case management
  - Clinical decision support and performance assessment
  - First Government health information system certified as a Complete EHR for Meaningful Use (Hospital and Ambulatory)
  - Many similarities to VA VistA, with as many differences
- Managed as a major IT Investment under Clinger-Cohen
  - Capital Planning and Investment Control (CPIC) processes
  - HHS Enterprise Performance Life Cycle (EPLC)
  - Reported on CIO Dashboard (http://it.usaspending.gov)

RPMS Utilization in Indian Country

- All Federal and most Tribal programs use RPMS – over 90% of patients served by IHS receive care at facilities using RPMS
- The complete RPMS EHR is in use at over 280 outpatient facilities including 34 Alaska Village Clinics
- 29 hospitals use RPMS EHR for inpatient care
- RPMS is also used outside IHS
  - Community Health Network of West Virginia (45 clinics)
  - Several facilities and public health nursing program in Hawaii and Pacific islands
  - Alaska state public health nursing program

X12 - 5010 Implementation Timelines

Date	CMS Compliance Step	IHS Status
January 1, 2010	Payers and providers should begin internal testing of Version 5010 standards for electronic claims	Competing priorities delayed 5010 development 1/1/2011
December 31, 2010	Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance	Internal testing began in 2011 and is ongoing
January 1, 2011	Payers and providers should begin external testing of Version 5010 for electronic claims; CMS begins accepting Version 5010 claims; Version 4010 claims continue to be accepted	CMS-IHS FI's begins accepting Version 5010 claims
December 31, 2011	External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance	External Testing began May 2011
January 1, 2012	All electronic claims must use Version 5010 Version 4010 claims are no longer accepted	IHS began February 2011 and will meet the January 1, 2012 deadline
October 1, 2013	Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures CPT codes will continue to be used for outpatient services	In November 2010, Steering Committee and Sub-groups established to address ICD-10 Implementation

IHS X12 Version 5010 Timelines

X-12 Phased Release	Release Date	Associated Activities
837P	May 2011	• Perform a practice-wide 5010 impact assessment • Obtain vendors' plans for software updates and/or testing schedules • Identify key practice metrics to monitor pre- and post-implementation • Finalize plans to update software, practices processes and internal policies
837I	September 2011	
**The 837I does not include development for ICD-10.*		

IHS X12 Version 5010 Timelines

X-12 Phased Release	Release Date	Associated Activities FY2012
837D	November 2011	• Obtain vendors' plans for software updates and/or testing schedules • Identify key practice metrics to monitor pre- and post-implementation • Finalize plans to update software, practices processes and internal policies
835	November 2011	
**The 837D does not include development for ICD-10.*		

IHS NCPDP Version D.0 Timelines

CMS Compliance Dates	IHS Dates	IHS Implementation Status
January 1, 2010: Internal Testing	April 2010	5.1 – D.0 GAP analysis
January 1, 2010: Internal Testing	October 2010	Planning
January 1, 2010: Internal Testing	December 2010	Developer Analysis
January 1, 2010: Internal Testing	February 2011	Development
December 31, 2010: Internal Testing	March 2011	**Alpha Testing**
January 1, 2011: External Testing	June 2011	D.0 Testing with Emdeon
December 31, 2011: External Testing	September 2011	Beta Testing

IHS ICD-10 Implementation Timelines

Activity	IHS Target Dates	Status
High Level Planning	November 2010	Complete
Awareness and Communication	November 2010	Ongoing
Detail Planning: Develop Tools, Processes to facilitate activities	December 2010	Ongoing
Requirements Analysis	July 2011	In Progress
Design	September 2011	In Progress
Software Development	February 2013	Not Started
Develop Training Approach	February 2013	Ongoing
Test/Deployment	June 2013	Not Started
Implementation	September 2013	Not Started

IHS ICD-10 Implementation

- Established an ICD-10 Steering Committee
  - Building organizational awareness and commitment
  - Identified key stakeholders (HIM, IT, Business Office, Revenue Cycle, Clinical)
- Evaluating systems and interfaces where codes are captured, exchanged, and reported
  - Assessing areas of risk
  - Identifying all systems that assign, utilize or store diagnosis codes
  - Identifying all processes/policies that utilize diagnosis codes
  - Identifying all contractors and business partners that rely on diagnosis codes
  - Obtaining vendor commitment for readiness
  - Evaluating interface engine support of ICD-10
- Developing a plan, and begun implementation activities

Summary of Key Challenges

- Resource Constraints (Financial and Staffing)
- Competing Priorities
    - Meaningful Use
    - Health Care Reform
    - Other Internal and External HIT Mandates
- Risk of Trading Partner 5010/ICD-10 Implementation Readiness
- Develop ICD-10 Expertise – Address internal needs and training
- Comprehensive Enterprise Preparedness as a result of many of the IHS remote locations

Questions

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Thank You

Where Are We Implementing 5010/ICD-10

Presented by

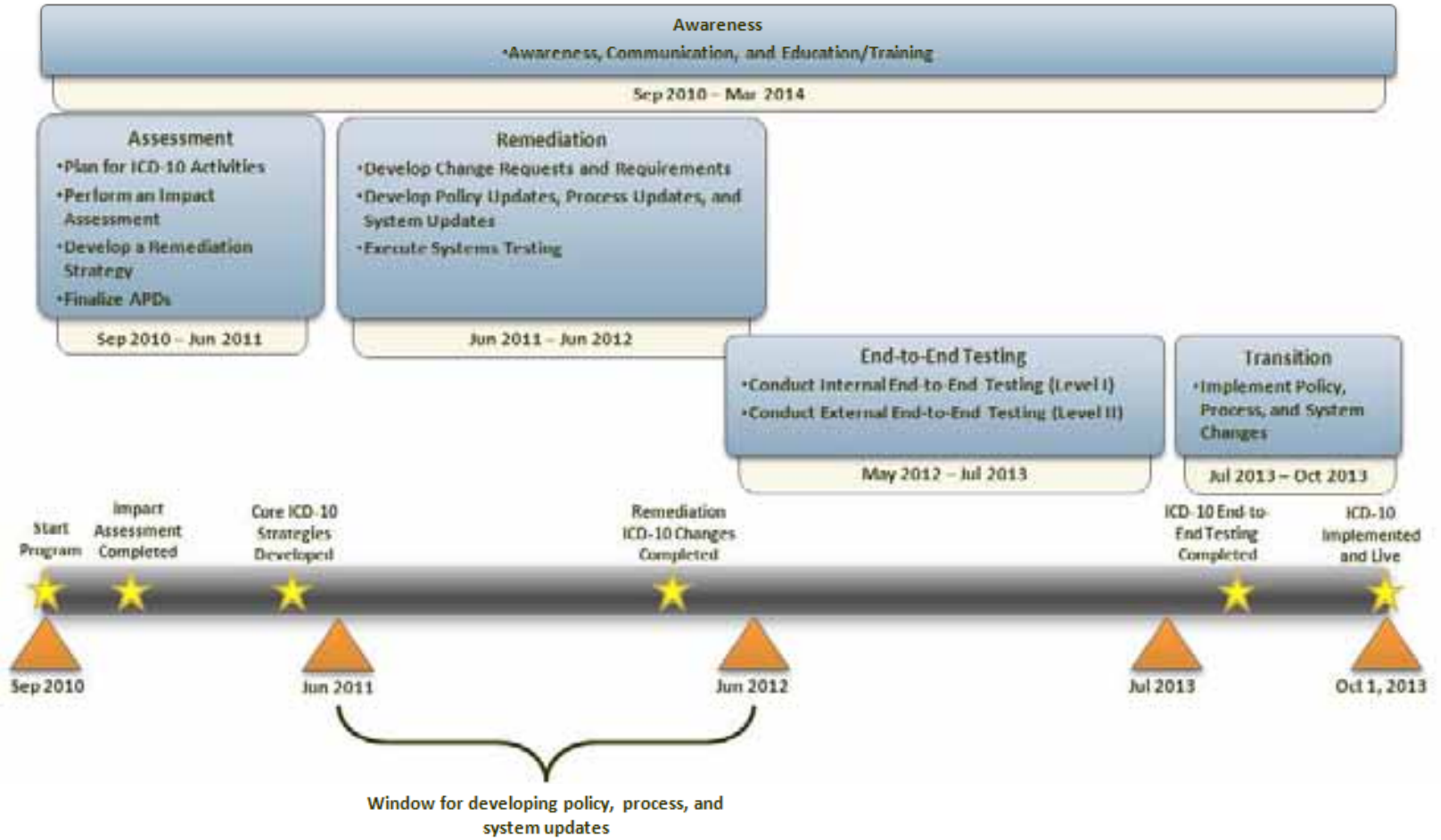
Elizabeth Reed

CMS, Division of State Systems

CMS Activities to Assess Medicaid ICD-10/5010 Implementation

- Online Readiness Assessment Tool (Apr '11/Dec '10, Qtrly 2011)
- MITA Impact Analysis (Aug 2010)
- SMA ICD-10 Implementation Timeline (Sep 2010)
- Site Visit Protocol (Oct 2010)
- Conference Calls with each State (mid Oct – early Nov 2010)
- Implementation Handbook and Templates (Dec 2010)
- SMA ICD-10 Training Syllabus and Materials (Jan 2011) – Training events in Atlanta, Seattle, Chicago, and Philadelphia
- Implementation Handbook Navigation Tool (Feb 2011): https://medicaidicd10.noblis.org/
- SMA Assessment Results

SMA High Level ICD-10 Implementation Timeline



5010 Readiness: Based on Conference Calls

- Small number of SMAs struggling to meet the 5010 compliance date
- SMAs are managing the following risks in their implementation programs:
  - Dependence on MMIS procurement or replacement for successful 5010 implementation
  - Convert inbound 5010 transactions to 4010 equivalent and leave the core MMIS largely untouched
  - Some SMAs still developing testing schedules
- Issues reported for 5010:
  - Funding
  - Competing priorities

Overall SMA 5010, D.0, 3.0, and ICD-10 Status

- ICD-10
  - 41 SMAs identify moderate to high risk for ICD-10 readiness –
  - Mitigation strategies in 2011 continue to reduce risk levels
- 5010, D.0, 3.0
  - Most SMAs verbally indicated confidence in being ready for 5010
  - Significant risk still exists around testing
  - Some SMAs indicate “high risk” for implementing D.0 and 3.0 by their compliance dates

5010 Edit Updates Status

Status of updating the edits under the 5010 changes	Percent of SMAs
No edits updates underway	8%
Developed edits requirements and change requests	18%
Designed edits changes	18%
Developed edits changes	12%
Performed edits tests	22%
Edits transitioned and implemented	6%
No response to assessment	18%

5010 Testing Status

Internal Testing Status	Percent of SMAs
No internal end-to-end testing begun	25%
Developed test plans and test data	20%
Internal end-to-end testing underway	35%
Internal end-to-end testing completed	2%
No response to assessment	18%

External Testing Status	Percent of SMAs
No external end-to-end testing begun	35%
Developed test plans and test data	24%
External end-to-end testing underway	22%
External end-to-end testing completed	2%
No response to assessment	18%

ICD-10 Impact Analysis Status

ICD-10 Impact Analysis Status	Percent of SMAs as of November 2010	Percent of SMAs as of April 2011
Completed	12%	14%
Started	27%	51%
Not Started Yet	61%	35%

CMS Assistance to States

- Navigation Tool for Technical Assistance
  - https://medicaidicd10.noblis.org/
  - Implementation Handbook electronically accessible allowing SMAs to easily search the handbook
  - ICD-10 Training Materials will be available via the tool in mid-May 2011
- RO Training Materials
  - Completed ICD-10 training materials including presentations, speaker notes, and examples
  - Recorded webinars for each training module will be available at a later date
- RO ICD-10 Training Workshops / SMA Site Visits (Apr – Jun 2011)
  - Completed the Atlanta RO training Feb 7-8, 2011
  - Completed Chicago/Kansas City RO training April 12-13, 2011
  - Completed Seattle/San Francisco/Denver/Dallas workshop for May 9-10, 2011
  - Completed Philadelphia/Boston/New York workshop for June 1-2, 2011

TOOLS AND RESOURCES

Additional Resources

CMS ICD-10 website:
www.cms.gov/icd10 →

Get Ready 5010 website:
← www.getready5010.org

Professional, clinical, trade associations

How to Stay Informed

- ICD-10 National Provider Teleconferences
  - CMS will be hosting ICD-10 national provider teleconferences on August 3
- CMS ICD-10 Website
  - http://www.cms.gov/ICD10
- CMS ICD-10 Industry E-mail Updates
  - https://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_608
- Latest News Page Watch
  - https://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_609

ICD-10 and Version 5010:
Industry Readiness Assessment and Communication

Christopher Handler, Ph.D.
Ketchum

Presented to the National Committee for Vital and Health Statistics
Subcommittee on Standards
June 17, 2011

Industry Readiness Assessments

Objectives

- Gauge health care industry's awareness of and preparedness for Version 5010 and ICD-10 transitions

- Provide direct input from target audiences to inform CMS outreach and education

Industry Readiness Assessments

Recent Assessments

1. In-depth interviews with primary audiences: vendors, payers, providers
2. Feedback assessment of industry partner organizations

Upcoming Survey

- Large-scale industry-wide randomized survey

In-depth Interviews

Interview Design

- Conducted Feb 1–Mar 1, 2011
- Telephone interviews (30 minutes)
- Separate questionnaires for vendor, payer, and provider audiences
- Sample size, n = 27 (9 vendors, 9 payers, 9 providers)
- All participants screened to ensure decision-makers interviewed
- Providers screened to focus on small practices (<10 physicians)

In-depth Interview Results

Key Findings

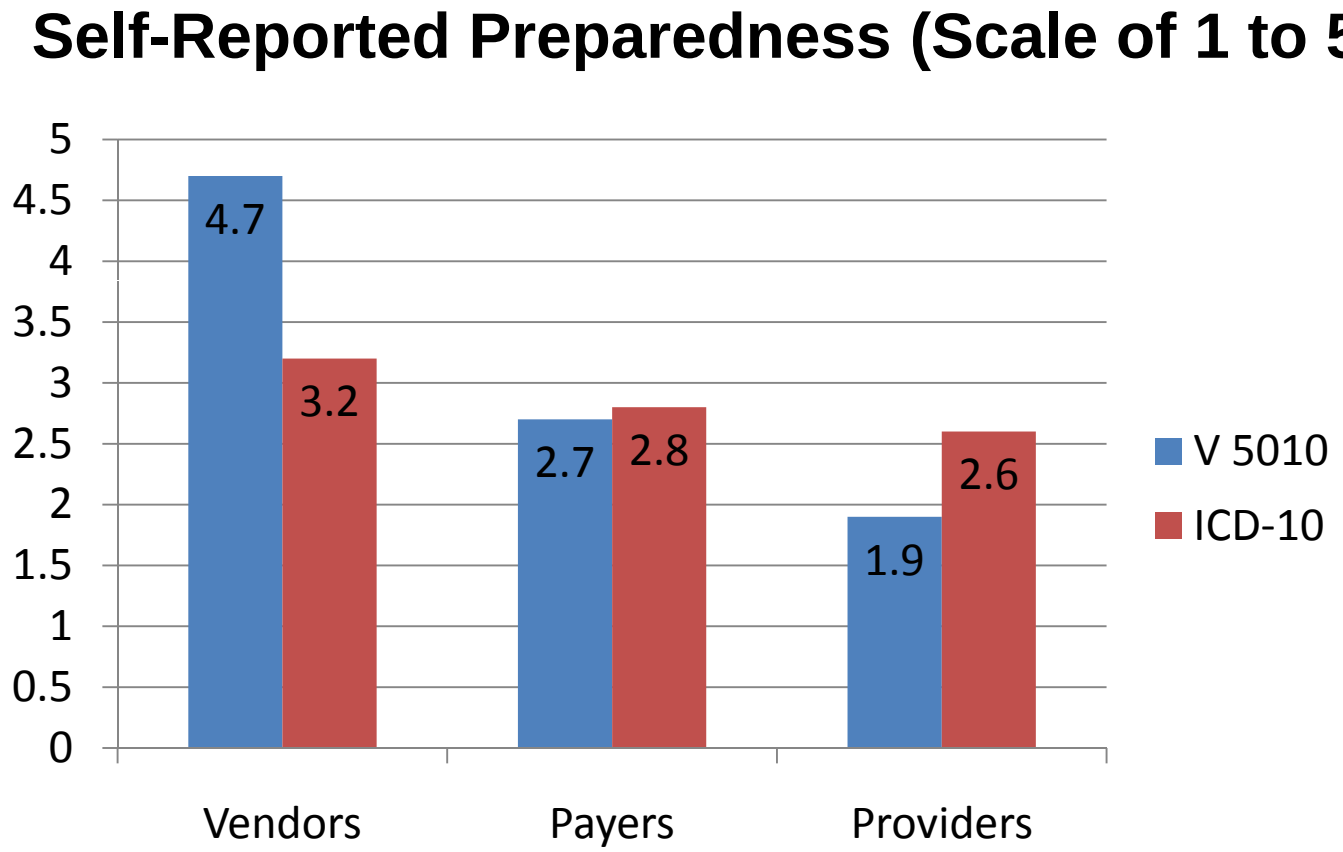
- Most participants confident they will meet deadlines
- Uncertainty remains about the compliance dates
- Participants understand consequences of not complying

In-depth Interview Results

Key Findings

- Most providers have begun preparing for ICD-10, but only one had secured an implementation budget
- About one-half of providers have talked with software vendor/developer about Version 5010, while the other half have not begun to prepare
- Overall self-reported preparedness levels:
  - Highest among vendors
  - Lowest among providers

In-depth Interview Results



In-depth Interview Results

Reported Concerns and Barriers

- **Vendors** – ability of payers and providers to transition on time
- **Payers** – providers' learning curve
- **Providers** – time and cost associated with learning the new codes

Partner Readiness Assessments

- Online survey fielded by partner organizations, Jan – Mar 2011
- Five participating organizations:
  - America's Health Insurance Plans (AHIP)
  - American Academy of Professional Coders (AAPC)
  - American College of Physicians (ACP)
  - American Medical Association (AMA)
  - Healthcare Billing and Management Association (HBMA)

Partner Readiness Assessments

Questions addressed:

- General awareness of transition
- Knowledge of transition deadlines
- Steps organization has taken action to prepare
- Expectations about meeting deadlines
- Barriers to compliance
- Timing of specific action steps to prepare

Partner Readiness Assessments: Results

- Results corroborate IDI findings that vendors and payers are more aware and prepared than providers
- Lack of time/staff cited as top barrier for those organizations not expecting to meet transition deadlines
- Respondents had limited knowledge about when their organizations would take specific steps to prepare for the transitions

Partner Readiness Assessments: Results

Org Name	V 5010 Aware	V 5010 Action	V 5010 Ready	ICD-10 Aware	ICD-10 Action	ICD-10 Ready	Sample Size	Margin of Error
AHIP	100%	97%	97%	97%	97%	97%	n = 31	± 18%
HBMA	100%	90%	79%	100%	87%	85%	n = 84	± 11%
AAPC	71%	55%	58%	99%	66%	67%	n = 201	± 7%
ACP	63%	30%	56%	70%	37%	59%	n = 84	± 11%
AMA	60%	35%	25%	55%	43%	45%	n = 40	± 16%

KEY

- *Aware* = Knew of transition before taking survey
- *Action* = Organization has taken action to prepare
- *Ready* = Expects organization to be compliant by deadline

Partner Readiness Assessments: Results

Top Barriers*

- The most frequently cited barrier across partner organizations was a lack of staff and time to make the transitions
- Other frequently cited barriers were budget constraints and other competing transitions
- Competing transitions were more of a concern for Version 5010 than for ICD-10
- Lack of an impact analysis was a concern for ICD-10, more so than for Version 5010

*As cited by respondents who did not believe or were uncertain their organizations would be compliant by the transition deadlines.

Partner Readiness Assessments: Results

Barriers to Transition Ranked by Partner Organization Responses

	Version 5010					ICD-10				
	AHIP	AMA	ACP	AAPC	HBMA	AHIP	AMA	ACP	AAPC	HBMA
Time/staff lacking	1	1	1	1	6	1	1	1	1	2
Budget constraints	1	2	2	3	5	1	2	2	3	4
Other transitions	1	3	3	2	4	1	7	5	6	1
External testing	1	6	6	6	1	1	7	6	5	4
Vendor coord	--	3	5	7	1	--	3	8	8	4
Internal testing	1	3	7	4	3	1	4	6	2	2
No incentive	1	8	4	8	--	--	4	3	6	7
Impact analysis	--	7	7	5	--	1	4	3	3	7

Upcoming Industry-wide Survey

Design

- Large-scale randomized survey
  - 400 providers, 100 payers, 100 vendors
- Same questions used for partner readiness assessments
- To be fielded this summer, upon OMB clearance

Objective

- Gauge level of industry awareness and preparedness to transition
- Target communication activities based on findings

CMS Outreach Efforts

- Advertising: 10.8 million impressions through 8/2011
- Earned media: 239,000 impressions through 6/2011
- Industry listserv: 24 messages in first 11 months, with 32,095 subscribers (as of 5/2011)
- Conference exhibits: 28,000 attendees
- Stakeholder engagement: ongoing activities with 30 industry organizations
  - Webinars; creation of ICD-10 websites; linking to CMS resources
  - AAPC Code-a-thon: 1,300 participants, 200 questions

CMS Outreach Efforts

Reaching Small Medical Practices

- Targeted materials: fact sheets, implementation timeline, widget
  - Provider implementation handbook
- Materials distributed at National Rural Health Association conference
- Ads in rural and regional outlets
- Presentations at regional meetings

Thank you

Update on the ICD-10-CM/PCS General Equivalence Mappings (GEMs)

Donna Pickett

NCHS

Rhonda Butler

3M

Standards Subcommittee

June 17, 2011

What are GEMs?

- **The GEMs are the raw material from which providers, health information vendors and payers can derive specific applied mappings to meet their needs**
  - **Used to facilitate linking between the codes in ICD-9 and ICD-10**
- **The GEMs can be used to assist in**
  - **Converting ICD-9 based systems or applications to ICD-10 based applications**
    - ***For more information on converting ICD-9 based systems and applications to ICD-10, see the MS-DRG conversion project report at: http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp***
  - **Creating one-to-one backwards mappings (also known as a crosswalk) from incoming ICD-10 based records to ICD-9 based legacy systems**
  - **Migrating ICD-9 historical data to a ICD-10 based representation for comparable longitudinal analysis**
  - **Creating ICD-10 based test records from a repository of ICD-9 based test records**
- **The GEMs can also be used for general reference**

What are GEMs?

- One entry in a GEM identifies relationships between one code in the source system and its possible equivalents in the target system
  - Source is the code one is mapping from
  - Target is the code being mapped to
- Each GEM file contains an entry for every source system code in the file
- A GEM file contains only those target system codes which are plausible translations of the source system code being looked up
  - For example, in the ICD-10-CM to ICD-9-CM GEM, each ICD-10-CM is translated only to the ICD-9-CM code(s) that are plausible translations based on the meaning of the ICD-10-CM code as contained in the code title, instructional notes, and index entries.

What GEMs Aren't?

- **GEMs are not crosswalks**
  - **The GEMs are more complex than a simple one-to-one crosswalk, but ultimately more useful. They reflect the relative complexity of the code sets clearly so that it can be managed effectively, rather than masking it in an oversimplified way.**
  - **They are reference mappings, to help the user navigate the complexity of translating meaning from one code set to the other.**

- **GEMs are not a substitute for learning how to use ICD-10-CM and ICD-10-PCS**

ICD-9-CM Coordination and Maintenance Committee

September 15, 2010

General Equivalence Maps (GEMs)*

- ***Section 10109(c) of the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (PPACA) requires the Secretary of Health and Human Services (HHS) to task the C&M Committee to convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9, and ICD-10, respectively), posted to the CMS website at http://www.cms.gov/ICD10, for the purpose of making appropriate revisions to said crosswalk. Section 10109(c) further states that any revised crosswalk be treated as a code set for which a standard has been adopted by the Secretary, and that revisions to this crosswalk be posted to the CMS website.**

ICD-9-CM Coordination and Maintenance Committee

September 15, 2010 (continued)

- **General Equivalence Maps (GEMs)***

The C&M Committee devoted the first half of the first day of the September C&M Committee meeting, 9:00 a.m. to 12:30 p.m. Wednesday, September 15, 2010, to fulfill the above-referenced PPACA requirements for this meeting to be held prior to January 1, 2011, and receive public input regarding the above-referenced crosswalk revision. No other meeting will be convened by the C&M Committee for this purpose. Interested parties and stakeholders should be prepared to submit their written comments and other relevant documentation at the meeting, or no later than November 12, 2010.

GEMs Comment Period Summary

- Extensive public comments received on GEMs
  - Approximately 5,200 GEMs entries were the subject of public comment
  - Comments received from:
    - Healthcare organizations
    - Providers
    - Payers
    - Vendors
    - Independent consultants
    - Other individuals in healthcare community

GEMs Comment Period Summary

- All comments/suggestions reviewed and considered
- Recommendations meeting inclusion criteria were incorporated
- Of the 5,200 comments submitted, approximately 1/3 were either implemented with the 2011 update or had been previously implemented in the 2010 update

GEMs Comment Period Summary

- Approximately 850 recommended changes (16% of all comments received) were new changes implemented for the 2011 GEMs
- Approximately 900 recommended changes (17% of all comments received) supported previous changes in the most recent updated files (posted Sept. 2010)
- Approximately 2250 recommended changes (43%) of all comments received) did not meet inclusion criteria
  - For more information on inclusion criteria, see “GEMs Documentation for Technical Users” at

http://www.cms.gov/ICD10/

When GEMs Inclusion Criteria Not Met

- The recommended change did not take into account the complete meaning of the code (i.e., instructional notes and index entries)

- Recommended change would allow more detailed translation alternatives than are supported by the level of detail in the source code system

Other Public Comments

- Out of scope comments
  - Requests for changes to ICD-10-CM and/or ICD-10-PCS
  - Comments on CMS reimbursement maps
    - Not covered by ACA requirements

FY2011 Update

- 2011 General Equivalence Mappings (GEMS) posted December 2010
- Updated files contain:
  - All changes to date in response to public comments as mandated by the Affordable Care Act, for the period ending Nov. 12, 2010
  - Changes reflecting internal reviews for accuracy and completeness
  - Changes reflecting previously received comments
  - Changes reflecting ICD-9-CM/ICD-10 code set updates

FY2012 GEMs Update

- 2012 General Equivalence Mappings (GEMS) posted December 2011
- Updated files will contain:
  - Changes reflecting ICD-9-CM/ICD-10 code set updates
  - Changes to date in response to public comment
  - Changes reflecting internal reviews for accuracy and completeness
- CDC/CMS continue to encourage comments on GEMs updates at future C&M meetings

Resources

CDC ICD-10 website

http://www.cdc.gov/nchs/icd/icd10cm.htm

CMS ICD-10 website

http://www.cms.gov/ICD10/