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Ensuring Provider Payment While Transitioning to ICD-10



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With little more than a year before the mandated shift from the *International Classification of Diseases, 9th Revision, (ICD-9)* to the *International Classification of Diseases, 10th Revision, Clinical Modification and Procedure Coding System, (ICD-10-CM and ICD-10-PCS, respectively)*, on October 1, 2014, all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) subject to this change find themselves at a challenging convergence of technology, heightened regulatory scrutiny, and increased specificity of professional documentation. The necessity of preparation cannot be understated, for po-

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tential negative economic repercussions to underprepared health care providers pose a very real threat.

The increased specificity in documentation of care provided has been a highly touted aspect of the implementation of ICD-10-CM and PCS. Perhaps no better illustration of this fact is a comparison of the number of codes contained in ICD-9-CM and those to be implemented with ICD-10-CM and ICD-10-PCS. Where ICD-9-CM contained approximately 14,000 code variations, ICD-10-CM contains approximately 69,000 diagnostic codes, and ICD-10-PCS has approximately 72,000 codes, which collectively include, among other distinctions, gender specific coding, anatomic specific coding, laterality coding, and inpatient hospital specific coding.

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The extensive expansion of the codes results in thousands of discrete, almost comical, event descriptions or applications. For example, ICD-10 contains specific codes for injuries sustained in a chicken coop, an opera house, a squash court and various locations in and around mobile homes. Further, where ICD-9 contained 33 codes for fractures of the radius, ICD-10 shows an exponential increase with 1,818 codes.¹ This increase in diagnostic specificity in the documentation of care pro-

¹ See Joseph C. Nichols, MD, Applications and Technologies Collaborative, ICD-10 Physician Impacts, Mar. 2011,

vided equates to a dramatic increase in the amount of information/data available for regulatory oversight targeted at eliminating fraud, waste, and abuse in the Medicare and Medicaid systems. The Centers for Medicare & Medicaid Services (CMS) has commented that the implementation of ICD-10, with its marked increase in specificity, will create a reporting environment adverse to fraud, waste, and abuse.

On February 11, 2013, the Departments of Justice (DOJ) and Health and Human Services (HHS) announced record-breaking recoveries in the ongoing and continuously heightened war against fraud, waste, and abuse through the Health Care Fraud and Abuse (HC-FAC) Program. Topping the \$4.1 billion recovered in fiscal year 2011, \$4.2 billion were recovered in fiscal year 2012. In 2012, CMS first implemented the Fraud Prevention System (FPS), which resulted in 536 new leads for fraud investigations as well as provided additional information for 511 ongoing investigations.²

Analytics Technology

In its 2012 report to Congress, CMS outlined and articulated the implementation of FPS. FPS is a state-of-the-art predictive analytics technology used to identify aberrant and suspicious billing patterns. This technology has been successfully implemented in the consumer financial services industry wherein it provides continuous automated oversight flagging aberrant transactions that may be based in fraud. Similar to preventive measures taken in the consumer financial services industry, where flagged transactions are not processed without verification, FPS provides CMS an ability to avoid “pay and chase” scenarios, flagging claims made under Medicare Part A and Part B. Flagged claims are then prioritized as leads of suspected fraud, waste, or abuse, which are then designated for investigation.

With the impending conversion to ICD-10, the amount of raw data available to be analyzed by FPS will increase significantly, making accurate documentation of care provided under ICD-10 crucial.

An important aspect of FPS is the continuous use of data and the evolution of various analytic models to evaluate claims. A distinct analytic model can be developed and then refined to focus on specific areas of fraud, waste, or abuse. For instance, “predictive models” may be developed based upon previous instances of fraud that reviews submitted claims searching for common characteristics associated with fraudulent

available at <http://www.christiancare.org/workfiles/medicaldentalstaff/icd10/ICD-10-Physician-Impacts-3-7-11.pdf>

² See Department of Health & Human Services and Centers for Medicare & Medicaid Services, Report to Congress Fraud Prevention System First Implementation Year, available at <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>

claims. Also, “anomaly detection models” can be employed that detect comparative abnormalities in claim patterns. Various evaluative criteria may be employed to detect anomalous claims, such as patient volume, procedure, and geography.

CMS utilizes the Integrated Data Repository (IDR) to create and modify analytic models. Established in 2006, the IDR as described by CMS is “an existing and continuously expanding repository of nationwide claims data.” The IDR allows for FPS to evaluate claims based upon current and historical data, which may prove problematic.

With the impending conversion to ICD-10, the amount of raw data available to be analyzed by FPS will increase significantly, making accurate documentation of care provided under ICD-10 crucial. However, this analysis will not only be for current claims but will also include a comparative historical analysis of previous claims. Without specifically defined crossovers between ICD-9 and ICD-10, the potential exists for the denial of claims based upon nothing more than an inadvertent lack of fidelity in the documentation of current care compared to that provided in the past, for just about 5 percent of the ICD-9 codes currently in use find a correlative counterpart in ICD-10 coding.

Vital Documentation

Because CMS is abandoning the “pay and chase” paradigm of fraud, waste, and abuse remediation, conscientious documentation will be vitally important in the event that a claim is flagged for review. Contingent upon the basis of review, adequate documentation may be necessary to ensure the receipt of payment or to avoid punitive measures for inadvertent erroneous billing. There is no transition period for the shift from ICD-9 to ICD-10, which means there is no grace-period for providers learning to utilize the new codes without facing any potential adverse regulatory action for an inadvertent error. Transitioning to ICD-10 requires a significant amount of effort on the part of a medical practice, which in all likelihood is stretched incredibly thin due to the current changes that it has already undertaken. It is important that providers recognize that the switch from ICD-9 to ICD-10 requires consistent administrative/executive level support.

What should providers do now to make sure they are ready for ICD-10? It is important to note that a change to effective utilization of ICD-10 will not occur on its own. Providers must take steps to prepare themselves and their staff for implementing ICD-10. First and foremost, assessing computer systems is a fundamental step in preparing for the transition. Many computer systems currently use ICD-9 codes as part of their operating logic. An impact assessment, which includes a system inventory, should be done as an initial part of ICD-10 transition planning. This could include practice management systems, electronic health record systems, contracts, clinical documentation, encounter forms/superbills, and quality reporting protocols.

Once the systems that will be impacted by ICD-10 are identified, applicable vendors should be contacted to ensure that those systems will be updated in time for compliance. Providers should confirm with each vendor that the system has been upgraded to Version 5010 standards, which will accommodate ICD-10 codes. Also, providers should inquire if vendors have any updates

for ICD-10 and when providers would be able to install the updates. Practices should also open a dialogue with payers, clearinghouses, and billing services in advance of ICD-10 implementation to discuss the transition and compliance plans. Test transactions should be done with payers and clearinghouses to test claims containing ICD-10 codes to ensure they are successfully transmitted and received. The impact of ICD-10 on payer contracts should also be discussed in advance of the implementation.

Although the implementation itself is a daunting proposition, planning and preparation will facilitate a successful transition.

It will be beneficial to identify a key person to spearhead the initiative of confirming that a practice is ICD-10 ready. This position is best given to someone with coding experience and knowledge of how coding is currently performed in the practice. This person should receive specific training on ICD-10 and its practicable impact on the practice. They can then become the point person in the practice and help with assessing

the practice's readiness for ICD-10 and planning the transition. A very large practice might require a point person on content and the substantive changes to the coding, as well as an additional person to lead the transition. This determination would be made based on the size and volume of the practice. In very small practices, staff may not be able to accomplish this transition on their own; in that event, outside vendors might be necessary to facilitate the change.

Staff, Provider Training

All staff members and providers need to receive at least some level of training with regard to ICD-10. This is also a good time to assess the practice's efficiency and any needs for process improvement. Immediately prior to the implementation date on October 1, 2014, staff should be given hands-on training in ICD-10 to familiarize them with the nuances and increased specificity found in ICD-10. Given the recent climate of regulatory oversight to eliminate fraud, waste, and abuse in health care, accurate documentation and billing of services are essential to avoid costly denials of payment and lengthy appeals processes merely to justify legitimate claims. Although the implementation itself is a daunting proposition, planning and preparation will facilitate a successful transition.