

## Managing the Liability Risks of ICD-10

Victoria L. Vance, Esquire

Tucker Ellis LLP

Cleveland, OH

### Introduction

The healthcare industry in the United States is on the brink of a massive upheaval to its operational infrastructure that will impact every business function throughout the organization. The conversion to ICD-10 is not just an information technology (IT) issue and it is surely not just a coding issue. Furthermore, it is not just a Medicare issue as all payors and providers covered by Health Insurance Portability and Accountability Act of 1996 (HIPAA) are affected. The conversion from ICD-9 to ICD-10 will increase both the number and complexity of billing codes and will necessitate changes in software systems, documentation standards, and workflows. Meeting the challenges, recognizing the risks, and minimizing disruption of this massive conversion will require careful planning, meticulous execution, and comprehensive training and support to employees throughout the organization. This article will highlight potential liability risks associated with the conversion to, and utilization of, the highly specific ICD-10 code set.

### Background

The International Classification of Diseases Clinical Modification version 9 coding system (ICD-9-CM) is the standardized system for categorizing diseases and patient conditions as well as surgical, diagnostic, and therapeutic procedures. The ICD-9-CM system has been the currency for healthcare billing and claims processing systems in the United States for thirty years and is the

underpinning of data analysis and reporting for internal healthcare management functions, quality and outcomes research, and public health reporting. In January 2009, the U.S. Department of Health and Human Services ordered the transition to ICD-10 and mandated the use of ICD-10 in HIPAA transactions (by health plans, providers, and clearinghouses) for all diagnoses and inpatient procedures effective October 1, 2013.<sup>1</sup> The ICD-9-CM Volume 1 and 2 will be replaced by ICD-10-CM to report diagnoses in all clinical settings; ICD-9-CM Volume 3 will be replaced by ICD-10-PCS to report hospital inpatient procedures only. To the rest of the world, this conversion in the U.S. healthcare industry is long overdue. The United States is one of the last developed countries in the world still clinging to ICD-9, a code set that is widely viewed as flawed and outdated since it does not reflect advances in medical terminology and technology, and is running out of space to accommodate new procedure codes. The conversion to the more-robust ICD-10 is mandatory for providers, payors, and clearinghouses. The magnitude of the process cannot be underestimated, as the conversion will affect such business areas as billing and claim payment, financial reporting, underwriting, disease/case management, payor contracting, provider relations, quality management, and customer service.

### Conversion Process—Goals and Benefits

The HHS Final Rule mandated that all services and discharges on or after October 1, 2013, must be coded using the ICD-10 code set, or else transactions will not be processed. The Final Rule implementing ICD-10 identified five major benefits that are expected to come about as a result of the transition from ICD-9 to ICD-10:

1. More-accurate payments for new procedures;
2. Fewer rejected claims;
3. Fewer improper claims;
4. Better understanding of new procedures; and
5. Improved disease management.

### Costs and Risks of Conversion

This is an extremely costly undertaking—both in terms of the cost to convert and the cost of failing to convert accurately, timely, and properly. The conversion costs include both hard and soft costs, new systems, personnel, training, increased claims-processing costs, and loss of productivity, and have been estimated to be on the order of magnitude of implementing HIPAA and Y2K programs. There is also a price to be paid for failure to convert. Delays or complications with the transition to ICD-10 may result in rejected claims, lengthy claims adjudication processes, and major disruptions of cash flow. Providers have been advised to have credit lines or backup financing plans in place to meet operational demands.



The ICD-9 system has approximately 13,000 diagnosis codes and 3,000 procedure codes, whereas ICD-10 has more than 68,000 diagnosis codes and 87,000 procedure codes. Further, the design of ICD-10 codes includes more characters and alphanumeric values, intended to provide flexibility to add codes in the future without disrupting the existing code structure. The conversion from old to new codes is not a simple matter of 1:1 mapping or crosswalking from ICD-9 to ICD-10. To the contrary, the majority of ICD-9 codes do not have an ICD-10 counterpart. In some situations, conditions that fit under a single ICD-9 code must now be scrutinized and assigned to the correct ICD-10 code from a list of extremely granular, anatomically precise code choices. It is the coding equivalent of taking a multiple choice test now with dozens of seemingly comparable answers. Selecting an appropriate new ICD-10 code will require a strong command of anatomy and a solid understanding of the medical care at issue. The new coding terrain creates risk of disagreement or honest mistakes in judgment about the most appropriate code to assign to a given claim. But, more ominously, the novelty of the new coding structure and inexperience of personnel and processes to recognize suspicious ICD-10 coding may create a breeding ground for fraudulent and abusive claim transactions.

In a healthcare setting, evidence of provider fraud and abuse can include submitting a claim for services not rendered, demonstrating a pattern of rendering nonmedically necessary services, and overutilization of services. Additionally, abusive practices include upcoding, duplicate billing, bill padding, and misuse of modifiers. In a 1998 survey, physicians admitted to manipulating reimbursement rules by exaggerating the severity of a patient's condition to help them avoid early hospital discharges, changing a patient's billing diagnosis, and reporting signs or symptoms that patients did not actually have to help them secure coverage for needed care. The physicians justified "gaming the system" as a covert form of patient advocacy and even a professional obligation.<sup>3</sup>

The gravity of an error in coding—whether intentional or not—is heightened by the fact that a single ICD-9 code may now "translate" to a list of conditions that carry a wide range of reimbursement rates. The temptation to correlate an old ICD-9 code with a new ICD-10 code at the high end of the reimbursement range is obvious. Fraud detection systems have become very sophisticated and are programmed to look for nonconforming billing patterns in claims. But with the advent of ICD-10, every claim will appear non-conforming. Simply put, the complexity of the ICD-10 coding scheme will make it difficult even for computer-based detection systems to recognize improperly coded diagnosis and treatment, at least for a while. This creates a vulnerability for the commercial and government payors.

## Risk Management

Navigating the ICD-10 conversion will be a daunting exercise for even the most-sophisticated organization. Survival tips include:

- Coordinate upgrades with vendors, billing services, payors, and clearinghouses, and conduct both internal and external tests of the systems to assure smooth transaction processing, both sending and receiving, well in advance of the ICD-10 effective date.

- Catalog all places where ICD-9 codes are used and develop a comprehensive strategic plan and timetable for implementing the conversion. Be sure all reporting tools, forms, and reports are compliant.
- Invest in training and educating everyone who documents in the medical record and acquaint them with the exacting level of anatomical and procedural detail required to support and justify the ICD-10 codes that will be assigned.
- Staff must be admonished not to embellish or retroactively revise the medical documentation to justify codes that do not apply to the medical circumstances or the care provided. Such alterations will be easily discovered in the emergency medical record and will not only raise questions about the accuracy and integrity of the medical record, but will be fodder for a billing investigation.
- Budget for postimplementation costs. Some consultants estimate that the residual ICD-10 conversion cleanup, include refining the organization's ICD-9 – ICD-10 mapping strategies, will persist for twelve to eighteen months.<sup>4</sup>

## Current Status and Conclusion

On February 16, 2012, bowing to pressure from the provider community, HHS announced that it would delay the October 1, 2013, ICD-10 conversion deadline. HHS cited its commitment to reducing regulatory burdens on providers, a not-so-veiled reference to other ongoing and costly compliance initiatives that providers are facing, and reaffirmed its commitment to the ICD-10 program. On April 9, HHS announced it would delay required compliance by one year—from October 1, 2013, to October 1, 2014.

This reprieve should provide HIPAA-covered entities valuable time to marshal and prioritize resources for eventually completing the transition to ICD-10 in an orderly fashion. Rather than celebrating this announcement as a derailment of ICD-10, the provider communities are well advised to take advantage of the continuance by: (1) emphasizing the importance of accurate and detailed medical documentation practices, not only to justify entitlement to the more exacting ICD-10 codes and thereby safeguard reimbursement streams, but also to improve clinical care; (2) practice coding protocols with well-trained administrative and coding professionals, and rehearse and self-audit data exchanges between payors and providers; (3) introduce new contracts, reporting templates, and business documents to accommodate the ICD-10 scheme where necessary; and (4) instill awareness among stakeholders to the need to protect the integrity of the new coding algorithms to guard against costly, fraudulent, and abusive practices.

1 74 Fed. Reg. 3328.

2 Centers for Medicare and Medicaid Services ICD-10 website, available at [www.cms.gov/ICD10/](http://www.cms.gov/ICD10/).

3 Wynia MK et al., *Physician Manipulation of Reimbursement Rules for Patients*, JAMA 2000; 283(14): 1858-1865.

4 Kasey J. et al., *ICD-10: Industry Perceptions and Readiness*, Millman White Paper, January 2010.