Cracking the Code: ICD-10 is Upon Us!
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ICD-9, the now ubiquitous method of categorizing disease and injury, was adopted in the United States in 1979, and has been the standard for decades. Every medical provider, health plan, insurance adjuster, or claims processor encounters ICD-9 codes regularly, if not on a daily basis. All of that is about to change. On October 1, 2015, all HIPAA covered entities will be required to transition from ICD-9 to ICD-10 code sets, pursuant to 45 CFR 162.1002 (HIPAA defines covered entities as (1) health plans, (2) health care clearinghouses, and (3) health care providers). Entities which are excluded from this classification, and therefore will not be required to make the transition to ICD-10, include workers compensation insurance, automobile insurance (both liability and medical payments), and other excepted benefits, such as certain on-site medical clinics. Although these coverages and entities will not be required to use ICD-10 coding, they will necessarily need to work with providers, plans, and other HIPAA covered entities which are required to make the transition, so there are clear incentives for anyone who deals with ICD-9 coding to make the transition to ICD-10, whether or not they are required to do so. These entities will also benefit from the increased specificity of ICD-10, and utilizing the same coding system as the medical providers and health plans with whom they will continue to need to work will avoid significant complications.

Claims for services provided on or after October 1, 2015 (or for inpatient stays, with a date of discharge on or after that date), should be submitted with ICD-10 codes, while claims for services provided prior to this date should be submitted with ICD-9 codes. The Medicare program has also announced that it will afford a 1 year grace period after October 1, 2015, during which claims won't be denied simply because the ICD-10 codes submitted aren't specific enough. This should not be mistaken for any grace period relating to the actual requirement to utilize ICD-10 codes; ICD-9 codes are not to be utilized by HIPAA covered entities after October 1, 2015, and claims submitted to Medicare which utilize ICD-9 codes will be denied.

ICD-10 coding provides for much greater detail and specificity regarding treatment than ICD-9 codes. ICD-10 diagnostic codes have between 3 and 7 characters, with the first three indicating the category, the next three providing detail regarding the etiology, anatomical site, and severity of the injury, and the seventh and final providing information regarding the encounter (for example, "initial" or "subsequent encounter"). An ICD-9 code which indicates "broken leg" could have a corresponding ICD-10 code under the new system which indicates something like "full fracture of left femur, slip and fall."

Although CMS has provided tools to aid in conversion (http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html), there are many more ICD-10 codes than ICD-9 codes, and the new coding provides for much greater specificity in describing diagnoses and treatment. This means that converting individual ICD-9 codes to ICD-10 codes accurately will be very difficult. When attempting to translate an ICD-9 code into ICD-10, there is a very significant possibility that unwanted and inaccurate medical information can be introduced, simply because the ICD-10 coding system provides for so much more specificity.

Take the example above of a code for a broken leg, for instance. Imagine an employee, Jane, slips and breaks her left femur at work. She is rushed to the hospital, undergoes emergency surgery, and is expected to make a full recovery. When the hospital submits the bills to the employer's workers compensation insurance, they do so using an ICD-10 code for "full fracture of left femur, slip and fall." workers compensation is still utilizing ICD-9, and translates the code as best they can, ending up with

"broken leg". All of the crucial, added information in the ICD-10 code is lost. Through an investigation, workers compensation determines that Jane had previously injured her right leg in a kayaking accident, and the injury had healed abnormally, leaving her especially susceptible to re-injury. Workers compensation then denies the claim based on a lack of causation, where if they were using ICD-10, they would see that it wasn't even the same leg. When entities communicating with each other use different coding systems, there is also an opportunity for the opposite problem: that unwanted (and inaccurate) medical information is introduced into a patient's record.

What Happens to Claims That Are Submitted With ICD-9 Codes After the Change-Over?

This will depend on the language of the plan document and any applicable agreements, such as PPO contracts, and how (and whether) they define a "Clean Claim". HIPAA does not provide specific guidelines relating to claim processing, it merely dictates which entities must utilize the new ICD-10 coding, and when they must begin. Whether a plan can deny a claim pursuant to the plan document and/or PPO contract for improper coding, and whether the plan can accept ICD-9 coding or require ICD-10 coding pursuant to HIPAA, will be distinct and separate questions.

For example, we examined a few plan documents for language which would impact this issue.

Sample 1: Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer.

This plan document provides for the "most recent edition of the ICD or CPT standards", so as soon as October 1, 2015 occurs, the plan can require providers to submit claims in ICD-10 format. Likewise, many plan documents do not explicitly require any specific format for claim submission, and under these plan documents both forms of coding would likely be acceptable. For example, this document provides:

Sample 2: Non-Network Claims

…It is suggested that each time you file a claim the following information is provided:

…

Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.

Finally, other plan documents contain specific references to ICD-9, which may create conflicts relating to whether the plan may accept claims in this format after October 1, 2015:

Sample 3: Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

This plan document specifically mentions ICD-9 format. Granted, it uses "or" and mentions Medicare guidelines, which will require ICD-10, so under these terms both formats could be acceptable. Pursuant to the terms of this plan document, claims submitted in ICD-9 format are still payable, despite the fact that under applicable law after October 1, 2015, both provider and payer are required to utilize ICD-10. This highlights an important aspect of the ICD-10 transition: ensuring that plan language and PPO agreements reflect the change and do not create a situation where the plan administrator must choose between enforcing Plan terms and complying with Federal law.

Preferred provider organization ("PPO")/network agreements also usually contain language which will be impacted by the switch from ICD-9 to ICD-10, and cause problems for an entity which is required to make the transition but fails to do so. For example:

Sample 4: Claim Records and Reporting Requirements. Company shall maintain appropriate records with respect to all payment determinations made with respect to Participating Provider claims for the duration of this Agreement and for seven (7) months thereafter. All Participating Provider claims shall be maintained in the original form or on electronic media. At [network]'s request, Company shall arrange to provide [network] with real-time and retrospective claims information in a mutually agreeable format … The claims information shall include, but not be limited to, patient and Subscriber identifier, claim number and check number, billed amount, allowed amount, paid amounts, payee (e.g. Member or Provider), billing codes, Provider name, Provider address, Provider TIN, date of service, date claim was received and date paid…

While these agreements generally do not address specific coding formats, it is certainly plausible that a network would deem ICD-9 coding to not constitute "appropriate records" or a "mutually agreeable format", particularly when dealing with a covered entity which is required by law to have made the change to ICD-10. This is the kind of disconnect which won't rear its head until some very large claims hang in the balance.

In addition to potential PPO network issues, failing to fully address the issues implicated by the ICD-10 change-over can have stop-loss repercussions. Stop-loss and reinsurance contracts almost invariably

condition reimbursement on the underlying claims being payable under the terms of the plan. Likewise, stop-loss will reserve the right to make an independent evaluation of a claim's payability, and need not defer to the plan's initial decision. When a plan pays claims submitted in ICD-9 contrary to either the terms of the plan or applicable law, or pays claims submitted in ICD-10 when the plan document requires ICD-9, stop-loss in either instance has a tempting and plausible basis to deny reimbursement and take the position that the claims should not have been paid by the plan. Any discrepancy between the plan document and either applicable law or plan procedures in practice creates an opportunity for stop-loss denials. This is an added incentive for plans to ensure their plan language conforms with applicable requirements.

Once Claims Are Erroneously Processed Due to Inappropriate ICD Coding, A Payer's Recourse is Very Limited.

It should be stressed that securing proper ICD-10 claim data is preferable to just converting codes. Because ICD-10 provides for much more detailed claim information, only an estimated 5% of codes have exact matches between the two formats. Although there are companies that convert codes and have prepared conversion references (CMS has prepared GEMs, or "General Equivalency Mappings", which are available at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html), approximating an equivalent ICD-10 code from an ICD-9 code will inevitably lead to inadvertently subtracting or adding health and treatment information. To avoid claims processing errors, and resulting overpayments, underpayments, or wrongful denials, plans should ensure their plan language aligns with current law, and require that claims be submitted in the proper format.

This is particularly true because if an overpayment is rendered due to the plan or TPA's mistake, it is very difficult, or impossible, to secure refunds from providers, absent any wrongdoing or misrepresentation by the provider. Although there is no regulation to our knowledge prohibiting a payer from converting ICD-9 codes to ICD-10 codes in good faith, an argument that the provider's submission of ICD-9 codes was wrongful or a "misrepresentation" will be weakened if the plan simply translates the codes and processes the claims rather than denying and requesting the correct format.

Remember Jane and her broken leg? Imagine Jane's employer didn't provide any workers compensation coverage, and her claims were instead submitted to her health plan. The provider submitted the claims in ICD-9 this time, indicating "broken leg". The Phia Group drafted the employer's plan document, so their language is great, and they would have no problem denying the claims because ICD-9 was used instead of ICD-10. The plan doesn't deny, though, instead opting to just convert the codes to ICD-10 and process the claims. They do the best they can, and end up with a code for "full fracture of right femur, blunt force trauma." The claims are paid, exceed the applicable specific deductible, and are submitted to stop-loss for reimbursement.

We all know where this is going. Stop-loss either: (1) looks at the ICD-10 code, discovers the kayaking accident and denies for third party liability, or (2) discovers the claims were submitted in ICD-9 and denies based on the fact that they should never have been processed in the first place. In either event, the plan is not being reimbursed, and any argument they had against the provider for submitting ICD-9 coding was lost when they took it upon themselves to convert the coding and process the claims.

All of this is just a brief glimpse at a few of the wrinkles which can and will come up when the healthcare world shuts the door on ICD-9, the system in use for almost 40 years. Starting on October 1, 2015, all HIPAA covered entities are required to utilize ICD-10 coding. This will include all medical providers and health plans, but not auto insurance coverage (either liability or first party/medical payments coverage), excepted benefits (such as on-site clinics), or workers compensation. Workers compensation adjusters, auto insurance adjusters, and attorneys will not be required by law to utilize or accept ICD-10 coding, as they are not "covered entities" under HIPAA's Privacy Rule (http://privacyruleandresearch.nih.gov/pr_06.asp). In practice, however, these entities will eventually need to accommodate ICD-10 codes, as all medical providers and health plans will be utilizing the new coding format. Further, all entities will benefit from the additional data found in ICD-10 codes. Some delay in making the change is to be expected, however, particularly on the part of those not directly impacted by the switch.

To be sure, there will likely be something of a transitional period where certain entities need to work with both coding systems. Plans, TPAs, vendors, stop-loss carriers, workers compensation and automobile insurance adjusters; all will regularly see both ICD-9 and ICD-10 codes for some time. To complicate things even more, in certain situations, such as where activities with a certain case or group of claims can span several months, one may expect to use both ICD-9 and ICD-10 coding on a single patient, course of treatment, or claim. And of course, the risk remains, however small, that certain non-covered entities continue to utilize only ICD-9 codes, requiring providers and other entities to have dual coding systems. Once the pieces are in place to actually make the change-over internally and utilize the new coding, the next step should be to engage a knowledgeable partner to ensure that plan documents and related agreements don't create any pitfalls for your plans, as well as stand ready to meet unanticipated problems as they arise. For more information, contact Ron Peck, Esq. at Ron.Peck@Phiagroup.com.