Has your health care organization mitigated the legal risks posed by the ICD-10 implementation?

Today, October 1, 2015, marks a significant event in the health care industry – the implementation of the ICD-10 code set. As physicians and other health care practitioners accept the robust expansion of available diagnosis codes into the daily practice of medicine, the legal and financial implications of the ICD-10 implementation to their organizations are serious. To mitigate the legal and financial risks associated with the implementation of ICD-10, it is critical to understand the regulatory guidance impacting the transition and prepare in advance for the challenges that will likely confront this change.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires ICD-10 to be utilized for the billing and record keeping of health care services. Effective as of October 1, 2015, ICD-10 replaces ICD-9 as the official system of assigning codes to diagnoses in the United States. Adoption of the ICD-10 code set affords greater specificity than the ICD-9 code set, and presumably, more insight into the incidence of diseases prevalent in health care today.

The transition to ICD-10 is required of all health care providers and insurers covered by HIPAA that submit claims to Medicare or Medicaid. However, the transition to ICD-10 has not been smooth, in large part due to the expansion of the number of available diagnosis codes. ICD-10 codes are three to seven characters in length and total approximately 68,000 codes; ICD-9 codes are three to five digits in length and total approximately 14,000 codes. As the
number of available diagnosis codes has more than quadrupled, health care providers have been challenged by the necessity of learning and understanding the new ICD-10 code set and implementing it into the practice of medicine.

As a result of the expansion of diagnosis codes and depth of specificity of the codes, the transition has come with significant planning and training, and not surprisingly, delays. The Final Rule replacing ICD-9 with ICD-10 was first published in 2009 and set for implementation on October 1, 2013. However, in 2012, the Department of Health and Human Services (HHS) announced a one-year delay and a new effective date of October 1, 2014. As the October 1, 2014 implementation date approached, new legislation further delayed the implementation date by yet another year, requiring use of ICD-9 until September 30, 2015.

**Guidance from CMS**

On July 6, 2015, in anticipation of potential lack of readiness among the provider community, Centers for Medicare & Medicaid Services (CMS) published a Frequently Asked Questions update advising health care providers that Medicare administrative contractors would not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 code for a 12-month period so long as the physician or practitioner utilized a valid code from the proper family of codes.

In a September 22, 2015 revision update entitled "Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities," CMS made clear that a valid ICD-10 code would be required on all claims effective October 1, 2015. In other words, Medicare claims with a date of service on or after October 1, 2015 will be rejected if they do not contain a valid ICD-10 diagnosis code. Moreover, CMS further clarified its recent guidance does not change the coding specificity required by national coverage determinations or local coverage determinations.

**Legal Implications of the ICD-10 Environment**

Now that ICD-10 is effective and health care providers are in the process of acclimating to the new breadth and depth of available diagnosis codes, a host of legal questions and concerns arise that affect all parties and intermediaries associated with the ICD-10 implementation.

*Automation Does Not Replace the Requirement of Documentation*

Over the next several months, physicians and other practitioners will focus much of their time and efforts on the selection of the most appropriate diagnosis codes. In doing so, however,
they remain responsible for ensuring the documentation of their patient encounter is thorough and contains sufficient detail to support the degree of specificity included in the diagnosis code assigned. As such, selection of an ICD-10 code does not replace the requirement to fully document the medical record as required by Medicare, Medicaid or any other government or commercial payer in connection with the reimbursement of medical claims. Importantly, physicians and other practitioners who assume the automation of an electronic health record will facilitate proper coding selection and completion of comprehensive documentation of patient encounters may be subject to legal and financial risk, including formal audits and requests for recoupments.

Review of Key Terms of Payer Agreements is Critical

Hospitals and physician groups should carefully review contracts with payers for purposes of coverage, reporting and other rules associated with the conversion to ICD-10. Medicare’s audit flexibilities only apply to Medicare fee-for-service claims from physician or other practitioner claims billed under Medicare’s Part B physician fee schedule. Commercial payers may or may not be offering similar flexibilities and “grade periods.” In addition, certain payers may not be fully ready for ICD-10 despite its effectiveness, and may include in their payer agreements protocols for claim submission or resubmission in the event of software issues or malfunctions. With the potential for a high degree of variance among payers relating to ICD-10 preparedness, as well as the likelihood of differing rules on protocols in place for proper submission of claims, understanding the key terms and conditions included in payer agreements is critical to assurances of financial stability during the conversion period and avoidance of formal disputes.

Proactive Coordination with Third Parties Reduces Risk of Lost Reimbursement

As with any significant transition, challenges can arise – but the anticipation of those challenges, and a proactive response to them, will mitigate the associated legal risk. Payers may deny claims improperly due to incomplete software system upgrades. Coding professionals may fall behind as they struggle with the implementation and vast number of new codes. Clearinghouses may not properly receive submitted claims or may inadvertently fail to submit claims to payers. Payers may not receive claims submitted in bulk by clearinghouses while hospitals and physicians await payment on those claims. In light of these potential instances of errors, it is important to be mindful of timely filing guidelines and to maintain close contact with all applicable third parties to ensure that errors are identified and resolved at their first occurrence. Otherwise, legal issues among providers, clearinghouses,
software vendors and payers over assignment of responsibility for unpaid and uncollectible reimbursements may result and add to the costs associated with the implementation of ICD-10.

**Practice Tips**

1. Identify all software systems affected by the ICD-10 transition and ensure they are properly updated in connection with the conversion to the ICD-10 code set.

2. Determine if your clinical documentation is sufficient to support the specificity required by ICD-10.

3. Ensure coding professionals, physicians and other clinicians alike receive proper ICD-10 coding and documentation training.

4. Regularly check in with your vendors – any transition issues they might be experiencing may impact your business operations.

For any questions about the legal risks associated with the ICD-10 implementation, please contact any of the Bryan Cave lawyers listed below.

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