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CLIENT ALERT

Why Providers Should Think About the Impact of ICD-10 on Managed Care Reimbursement Now

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ICD-10 implementation has been delayed by Medicare until October 2015. Many believe it may be delayed again and are putting off thinking about its impact until it is clear that the updated code set will be implemented by Medicare. However, providers need to appreciate that many of the managed care agreements that they are signing today likely include binding language that will impact reimbursement changes resulting from ICD-10 implementation, particularly for inpatient services.[1] Proactively thinking through such provisions, and their implications, now may avoid heartache later (even if ICD-10 were to be delayed again).

Many commentators have focused on the coding details of the ICD-10 transition and the language and coding specificity that will be required. What may be overlooked in these coding discussions is that the updated code set will not only allow, but will likely require, changes in the way that plans reimburse for certain services and coverage is determined.

When ICD-10 replaces ICD-9, the number of diagnostic codes available for coding health care services will roughly quintuple, going from 13,000 codes to 68,000 available codes. The identification and submission of diagnosis and procedure codes is a key function of health care reimbursement in the United States. For inpatient services, diagnosis and procedure codes are often grouped through software programs into diagnostic related groups ("DRGs"). These "groupers" are central to the claims and payment process for inpatient services because most claims payment is based on the identified DRG. As part of ICD-10 implementation, new DRG "grouper" methodologies will be needed to translate the new codes into DRGs for payment. The Centers for Medicare & Medicaid Services and payers will need to test the new "groupers" once they are developed. For some services, it is extremely difficult for providers to predict what the actual impact on reimbursement will be.

[1] The conversion to the International Classification of Diseases – 10th Edition ("ICD-10") will impact outpatient claims to the extent that the record and claim utilize diagnosis codes. The conversion to ICD-10 does not affect the Current Procedural Terminology ("CPT") coding for outpatient procedures.

For inpatient services, reimbursement rates that are based on a percentage of what Medicare pays will likely be impacted the least. Reimbursement rates that are based on negotiated case rates tied to specific DRGs will likely be impacted the most, as such case rates will need to be adjusted or reassigned to DRGs within a new grouper methodology. Reimbursement based on other payment methodologies may be impacted as well.

Some managed care agreements already address, in a general way, how new grouper versions are to be handled since grouper versions are updated from time to time. For example, some managed care agreements may require a health plan to implement new grouper versions within 30 to 90 days and to ensure that the change is "revenue neutral" to both parties.

Some managed care agreements may address ICD-10 conversion specifically, for example, by requiring providers and even the plan to comply with ICD-10 in claims submission and payment processes as of the implementation date. Agreements for reimbursement of inpatient services based on case rates tied to specific DRGs will require plans to implement new rates in conjunction with ICD-10 implementation. Since ICD-10-related grouper methodologies have not been released and tested as of the date of this writing, it is impossible to predict how such rates will need to change, yet such agreements typically have multiyear terms with no right to terminate early, except for material breach. Some agreements may address the rate changes needed for the ICD-10 conversion process by requiring that such changes be “revenue neutral” to the parties. Such provisions specific to ICD-10 issues may conflict with more general language in the same agreement regarding new grouper versions.

A significant question that arises in an agreement that has a provision requiring that rate changes be “revenue neutral” is this: “What does ‘revenue neutral’ mean?” Who decides what it means? It may not be easy to determine what “revenue neutral” means when comparing what was paid for a particular service using an earlier DRG grouper version based on ICD-9 codes to what is proposed to be paid for a service using a new DRG grouper based on ICD-10 codes. Among other reasons, medical record documentation will look different under ICD-10, so unless a record is documented for ICD-9 as well as ICD-10, it may be like comparing apples to oranges.

Often the language in a managed care agreement will allow the plan to decide what “revenue neutral” means and possibly give providers a right to dispute the plan’s interpretation. Perhaps the provider may need to first demonstrate that the alleged change in reimbursement has nothing to do with “case mix changes” (which may be impossible to prove, especially given changes to medical record documentation). A provider may have a limited window in which to raise a dispute, and may not have adequate data or access to data to decide if it has a dispute. With no clear right to audit or to have an independent third party verify that rate changes are “revenue neutral,” providers may find themselves locked into long-term agreements with no good recourse if their rates change post-ICD-10 implementation. This difficulty could be magnified if the agreement explicitly permits a plan to make a determination as to rate changes, thus

limiting a provider's ability to claim that the impact from the ICD-10 conversion is a material breach of the agreement.

Even if the parties to an agreement have agreed to an acceptable process to ensure that rate changes are revenue neutral, since claims billing and payment systems will need to undergo change for the ICD-10 conversion, there is also the possibility that such system changes will not be ready, creating a "cash flow" issue for providers.

The ICD-10 conversion will also have a ripple effect on a managed care plan's coverage and payment policies and reporting systems that are based on diagnostic codes, requiring updates for ICD-10 codes. Changes to such policies and reports may impact reimbursement as well.

Because significant payment disputes are possible, providers should proactively address the ICD-10 issues in their current contract negotiations. We suggest any provisions addressing grouper changes, specifically addressing ICD-10, those referencing "revenue neutral" requirements and provisions dealing with policy and manual compliance be carefully evaluated in current contract reviews. And a clear, fair dispute resolution provision for ICD-10 conversion is also recommended.

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This Client Alert was authored by **Jackie Selby** *and* **Bethany J. Hills**. *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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