GENERAL DYNAMICS
Information Technology

White Paper: The Impact of ICD-10 on Fraud, Waste and Abuse Detection

Although replacing International Classification of Diseases-9 (ICD-9) with ICD-10 code sets is expected to bring greater accuracy to diagnostic and procedural coding, and could produce cost savings, the transition to ICD-10 code sets poses immediate challenges in fraud detection – difficulties that will require planning, coordination and communication across all healthcare providers and payers.

Considered one of the most far-reaching and complex regulatory mandates for U.S. healthcare organizations, including providers, payers and other intermediaries such as claims clearinghouses, ICD-10 touches on nearly every aspect of treatment, billing and payer claims processing. ICD-10 increases the 13,500 diagnostic codes under ICD-9 by five times to nearly 70,000 codes, and code structure from three-to-five predominately numeric characters to three-to-seven alphanumeric characters.

Industry observers predict ICD-10 will surpass Y2K and HIPAA compliance in terms of time requirements, financial investment and technological changes required to accommodate conversion. Industry-wide the estimated price tag for conversion may reach $14 billion, which translates to about $285,000 for a typical 10-physician practice, to approximately $2.7 million for a large practice. The additional costs required include everything from software upgrades, to system expansions, new user interfaces, data model changes, code crosswalk tools, recreating of reports for financial, clinical reimbursement and quality analysis, as well as staff training and other charges associated with workflow alterations.

Most urgently, not being in full compliance with ICD-10 by October 2013 will result in providers not being able to bill, submit and receive payment for services, and payers not being able to receive and process claims.

And within healthcare payment organizations, claims adjusters, Special Investigations Units (SIU's) and others evaluating medical claims face multiple daunting challenges. There are concerns SIU's will see increased fraud, waste and abuse (FWA) referrals due to confusion and increased customer service inquiries. There's also an increased risk of false positives, as the standard FWA analytics engines must be re-calibrated to adjust for the code set overhaul and anticipated erratic billing patterns.

The Importance of Fraud Detection

When it comes to evaluating medical claims, U.S. healthcare insurers and providers lose billions annually to FWA, as an estimated four to ten percent of all health insurance claims contain FWA. In converting to ICD-10, key challenges revolve around quality and reliability. SIU's and other investigators must question the ability to trust the data. There will be an urgent need for accuracy in mapping and translation routines. And the possibility for errors will only underscore the requirement for training all billing staff as errors will creep into all areas from vendor software, to billing and EMR solutions, making fraud detection more challenging.

ICD-10 Basics

The World Health Organization (W.H.O.) publishes the ICD. The codes are used worldwide for morbidity and mortality statistics, reimbursement systems and automated decision support. In the U.S., ICD-10 includes:

- ICD-10-Clinical Modifications (CM) for diagnosis codes that determine the health of the patient;
- ICD-10-Procedure Coding System (PCS) for surgical or diagnostic procedure codes performed in an inpatient setting.

The U.S. Department of Health & Human Services (HHS) has mandated that ICD-9 will be replaced by ICD-10 on October 1, 2013. All HIPAA-covered entities must comply with this date.

At the same time, trending abnormalities will make it difficult to 'normalize' and match/compare diagnosis and treatments over expanded timeframes. It's unclear how long it will take to overcome the learning curve involved in migration. SIU's and other claims investigators must figure out how to interpret pattern changes in data or behavior. Will investigators see an increased sickliness of patient load, as healthcare practices attempt to recover ICD-10 migration costs?

And the timing of conversion also causes concern. The absence of a ramp-up period will likely lead to interrupted billing patterns, which will make it difficult for claims investigators to adjust data driven analytics. How, for example, will they analyze blended data from comingled ICD-9 and ICD-10 forms? It's highly likely that SIU's will see increased fraud referrals due to confusion and higher number

of customer service inquiries for at least several months after October 2013.

In addition, it's likely the risk of false positives will increase. Re-calibrating FWA analytics to adjust for the code set changes and simultaneously erratic billing patterns will be challenging. The best course of action for investigators when data doesn't make sense will be to research crosswalk logic. It's also expected that peer-group outlier analysis will become more valuable, as the new 'normal' will hit quickly and the receipt of resubmissions and adjustments will skew statistics. The new code set will require modifications and new rules, algorithms, decision trees, statistical models and other analytic concepts. And to complicate matters further still, correlating the differing terminology in both ICD-10 procedure codes and CPT surgical procedure codes, will make investigations more challenging.

Ultimately, SIU's will find it difficult to prove when errors are a mistake, intentional or illegal. Deciphering whether documentation is complete, true and correct will drive an increased need to monitor providers. Some healthcare payment organizations may need to consider instituting a grace period during the transition. Others may decide to increase audits or even temporarily suspend audits as everyone adjusts to the new coding format.

Add to all of the complexities an ongoing shortage of coders, with many planning to retire in the near future, and it's increasingly clear coding work will change dramatically. Even certified coders must be recertified to work with ICD-10 codes. Luckily, the American Academy of Professional Coders (AAPC) offers training and will re-test coders, in an open book test consisting of 75 questions that can be administered online. Coders will have a two year window from Oct. 2012 to Sept. 2014 to obtain recertification.

Why Convert?

With so many obstacles, some may doubt the transition to ICD-10 is worth the effort. However, according to the American Health Information Management Association (AHIMA), there are a number of valuable reasons to complete conversion, including:

- Greater coding accuracy and specificity
- Higher-quality information for measuring healthcare service quality, safety and efficiency
- Reduced coding errors
- Greater achievement of the benefits of an electronic health record
- Alignment of the U.S. with coding systems worldwide
- Improved ability to track and respond to international public health threats
- Enhanced ability to meet HIPAA electronic transaction/code set requirements

In the meantime, however, it will be crucial for healthcare organizations to take steps now to help ease the transition, including:

- Review the new coding guidelines
- Identify general impact of coding changes
- Review crosswalks – vendor, internal and government-available
- Identify changes to current reports/ trending involving ICD-10
- Identify any new processes needed because of ICD-10
- Help shape the organization's ICD-10 training program and messaging
- Get involved in revamping policies and contracts.

ICD-10 ultimately represents an opportunity to make policies and contracts clearer and stronger in the years after the mandated transition. ICD-10 is expected to build a powerful repository of detailed healthcare information, and will eventually provide better data with which to uncover potential fraud and abuse.

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