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ICD-10: Changing Payment Considerations

Written by Joseph C. Nichols, MD

As we draw closer to the Oct. 1 implementation of ICD-10, concern about impacts to payment is increasing. On the inpatient side, hospitals are already well aware of the financial relevance of ICD-9 codes, yet the financial impact of ICD-10 is even easier to grasp. On the ambulatory side, the financial impacts are not as obvious. Many physicians believe that there is no financial relevance to ICD-10 codes, because they are paid on service codes and not on ICD-10 codes. Beyond ICD-10 requirements, payment reform that incorporates transparency and accountability when it comes to value-based purchasing is a growing trend. It is highly likely that the current payment models will continue to change to support the concept that we should pay for not only "what" was done, but "why." There is a general sense by those purchasing or managing care that payment should be focused primarily on maintaining or improving health conditions and less focused on healthcare services. Models of payment based on episodes of care and provider risk sharing are continuing to evolve. Let's look at some of the impacts based on current methodologies as well as anticipated new methodologies.

DRGs and other grouped payment methodologies

DRGs are mature models that have been around for quite some time. Diagnostic coding plays a role in determining payment in DRGs, and it's well-known that inaccurate coding means inaccurate payment. The remediation of DRG groupers to support ICD-9 and ICD-10 natively has been focused on maintaining revenue neutrality initially, but it is clear that revenue neutrality is not the long-term goal. ICD-10 will provide the ability to distinguish between significant differences in severity, comorbidities, complications, complexity, and other important parameters that are significant factors in patient risk and cost of care. Once there is sufficient data to recognize this difference in risk and severity, DRG weighting will have to be readjusted to reflect this difference[1]. Despite the focus on revenue neutrality, current groupers that support both ICD-9 and ICD-10 codes will have cases for which there is a DRG shift for the same clinical scenario. Some payors may be crosswalking back ICD-10 codes to ICD-9 codes in order to run the grouper; others may be using the grouper with native codes. There will be a difference in payment in some cases, depending on the payor approach.

Audit-based and other post-payment or post-care delivery recoveries

Post-payment recoveries pose a substantial financial risk. More than $5.4 billion has been collected through the Recovery Audit Contractor (RAC) program since its pilot was launched in 2010. In 2012 alone, collection for overpayments exceeded $2 billion[2]. Each year the collected total has risen

significantly. Coding and issues with the documentation used to support submitted codes are the primary basis of these payment recoveries. There is considerable concern that the transition to ICD-10 will create an uncertain environment for recoveries on both the auditor and provider side during the period in which a learning curve persists. Other methodologies that are focused on hospital acquired conditions, preventable readmissions, or other measures of care delivery are becoming a prominent part of the payment equation. ICD-10 will factor significantly into these determinations.

Risk sharing and risk adjustments

Provisions of the Patient Protection and Affordable Care Act and other regulatory changes are establishing an environment in which provider-level risk sharing for the care of a population is becoming as prominent as healthcare financing considerations. Gain sharing for cost savings and other incentives are becoming more of a reality. Small differences in the details of patient conditions have major impacts on cost and the risk of adverse outcomes. Any risk-sharing methodology must include more robust risk adjustment approaches. ICD-10 establishes, at a greater level of specificity, the information needed to assist in risk adjustment. If, however, providers continue to use vague and unspecified codes, the risk will be assumed to be at the lowest level, given the condition. Recognizing differences in severity, complications, comorbidities, and other parameters of patient conditions that indicate substantial risk will require reporting these more detailed definitions in ICD-10 codes.

Any organization that attempts to manage financial risk of the population without detailed health condition data will be at a significant business disadvantage.

Episode-based payment

A number of payment methodologies involve the use of episode groupers to define each patient's episode of care. The logic involved in these groupers is much more complex than that of DRG groupers, which consider an inpatient stay the "episode," from a time perspective. On the outpatient and professional side, there is considerable complexity regarding defining time frames for different conditions, defining the codes that would be included within each episode, and attributing those episodes to a provider. There has been a considerable body of work completed in very complex logic for defining "episodes of care" by different academic and commercial entities, but most of that logic will need to be rewritten because of the shift in diagnostic codes. Without historical ICD-10 data, it will be difficult for some time to determine the validity of those complex grouping algorithms in an ICD-10 environment. There are other simpler "episode-like" models that are being explored and considered as alternatives for the fee-for-service based approach used today.

Summary

The migration to ICD-10 will have a significant impact on payment for a variety of reasons, given the existing payment methodologies in place today in both the inpatient and ambulatory arenas. As we move

forward into a new healthcare environment, payment methodologies are likely to incorporate both "what" was done and "why." Coding specificity will become progressively more important in ICD-10 as the key parameters of the patient condition become an important consideration in payment methodologies.

About the Author

Dr. Nichols is a board certified orthopedic surgeon with a long history in health information technology. He has a wide range of experiences in healthcare information technology on the provider, payer, government and vendor side of healthcare business. He has served in positions in executive management, system design, logical database architecture, product management, consulting and healthcare value measurement for the last 15 of his 35 years in the healthcare industry. He has given over 100 presentations nationally related to ICD-10 over the past three years on behalf of payers, providers, integrated delivery systems, consulting groups, CMS, universities, government entities, vendors and trade associations. He co-chairs the WEDI (Workgroup on Electronic Data Interchange) translation and coding sub-workgroup and has received WEDI merit awards three years in succession. He is also an AHIMA approved ICD-10 coding trainer. He is currently providing consulting services as the president of Health Data Consulting Inc.

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1 http://www.cms.gov/mmrr/Downloads/MMRR2011_001_02_A02.pdf

2 http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY2013-3rd-Qtr.pdf