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Eli's Rehab Report

ICD 10 Update: Safe Harbor Proposed For ICD-10 Transition

New legislation to protect providers' reimbursement.

There's good news for you, especially if you are apprehensive about the impact the ICD-10 transition will have on your bottom line. Rep. **Diane Black** (RTN-6) introduced a new bill in the **U.S. House of Representatives** on May 12, called H.R.2247, or the Increasing Clarity for Doctors by Transitioning Effectively Now Act (ICD-TEN Act) which does not ask for a delay in implementation of ICD-10-CM/PCS. Nor does it ask for acceptance of the much hyped dual coding either.

The onus is on HHS now: The bill would require the **Department of Health and Human Services** (HHS) to conduct "comprehensive, end-to-end testing" to assess whether the Medicare fee-for-service claims processing system based on the ICD-10 standard is fully functioning. HHS would need to make the end-to-end testing process available to all providers of services and suppliers participating in the Medicare fee-for-service program.

Within 30 days of the completion of the testing process, HHS would submit to **Congress** a report on whether or not the Medicare fee-for-service claims processing system is fully functioning as per the ICD-10 standards.

Pass the litmus test: The benchmark for HHS is to prove that it is processing and approving at least as many claims with ICD-10 as it did in the previous year using ICD-9.

If this benchmark is not attained, the transition might not be deemed "functional." In such a scenario, HHS would need to identify additional steps to ensure ICD-10 is fully operational in the near future, according to the bill.

The proposed transition period: The bill proposes to implement an 18-month "safe harbor" transitional period after the October 1, 2015, implementation date to protect providers should they make a "minor" mistake using the wrong ICD-10 sub-code. During this 18-month proposed transition period and any ensuing extensions, the bill recommends that no reimbursement claim submitted to Medicare be denied due solely to the "use of an unspecified or inaccurate subcode."

"During the ICD-10 transitional period, it is essential for CMS to ensure a fully functioning payment system and institute safeguards that prevent physicians and hospitals from being unfairly penalized due to coding errors," explains Black, in her letter.

Know Why AHIMA Doesn't Feel the Same

The **American Health Information Management Association** (AHIMA) is not in favor of this bill. The group says that CMS already has ICD-10 contingency plans well in place, capable of ensuring that the industry is ready to effectively use ICD-10 in October. According to the AHIMA CEO **Lynne Thomas Gordon,** CMS has done ample outreach and preparation to help the industry prepare.

In that context, CMS has already been conducting end-to-end testing with providers, and the results show a positive trend, on par with the ICD-9 claims. According to results from the first week of CMS testing held from January 26, 2015 to February 3, 2015:

- 81 percent of test claims submitted by providers in ICD-10 were accepted.
- Only three percent of rejected claims were due to invalid submission of an ICD-10 code.
- Other claims were rejected because of errors unrelated to ICD-10.

This trend is a good indicator of the healthcare industry's readiness for ICD-10 on October 1, 2015.

More steps from CMS: In addition:

- Providers, suppliers, billing companies and clearinghouses can submit test claims to Medicare any time up to the October 1 implementation date.
- CMS could grant "advance payments" to any physicians that do experience cash flow disruptions as a result of the ICD-10 transition.
- CMS already has existing payment policies for a provider who has incurred a temporary delay in its billing process causing financial difficulties for a provider. This could help providers after the ICD-10 transition.

New bill may be prone to abuse: AHIMA officials believe that as of now, significant payment disruptions for physician practices are not likely since testing has demonstrated that CMS systems are ready to accept and process ICD-10 claims. On the other hand, the proposed 18-month grace period in the new bill, which is expected to go soft on denials, would "create an environment that's ripe for fraud and abuse," according to **Margarita Valdez,** senior director of congressional relations at AHIMA. As per the provisions in the new bill, it prevents the rejection of claims and denial of payment based solely on subcoding specificity during the implementation phase.

Bottom line: "If the provisions in this bill are properly used, then the provisions in the bill are appropriate," contemplates **Duane C. Abbey, PhD,** president of **Abbey and Abbey Consultants Inc.,** in Ames, IA. He further explains, "Thus, if there are relatively few claims in which the subcode violations exist, and then the legislation has probably attained its intent. However, if it is used as a crutch just to get claims to go through, then fraud and abuse concerns will be raised."

This bill has been referred to the Committee on Energy and Commerce and the Committee on Ways and Means for further contemplation.