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The Consequences for Private Practice Physicians after Transitioning from ICD-9 to ICD-10

On October 1, 2015, all parties covered by the Health Insurance Portability and Accountability Act (HIPAA) were required to transition from ICD-9 to ICD-10 coding.¹ Consequently, the detailed coding and the increased liability with ICD-10 has led to an increase of doctors in the United States leaving private practice for hospital employment. Fifty-seven percent of physicians were independent in 2000, but the number of independent physicians has decreased over the years with thirty-seven percent of independent physicians in 2013.² The percentage of independent physicians is projected to continue to decline to thirty-three percent by the end of 2016.³ The issue arises from the fact that physicians choose the medical field out of a desire to take care of patients and not because they want to become coders. Consequently, coding has become an important part of the medical field because physicians are paid for their services through billing codes.

In the fee-for-service system, healthcare providers are paid for each service separately, which incentivizes physicians to provide more treatment because payment is dependent on the quantity of care rather than the quality of care. While many practices try to manage most of the coding work for the physicians, the provider is ultimately responsible for the coding that is sent out with insurance claims. The specificity and complexity of ICD-10 coding will increase provider liability for physicians operating private practices because it will make it easier for the government to show that a physician has “knowingly” selected the wrong code under the False

¹ *ICD-10 Overview*, Ctrs. for Medicare & Medicaid Servs. (Dec. 2, 2016, 4:09 PM), <http://www.cms.gov/medicare/Coding/ICD10/index.html>.

² Kristin Ficery, *Clinical Care: The Independent Doctor Will NOT See You Now*, Accenture (2015), <http://www.accenture.com/us-en/insight-clinical-care-independent-doctor-will-not-see-you-now>.

³ *Id.*

Claims Act (FCA); thus, physicians are deterred from opening private practices in order to avoid the risk of severe penalties.

I. INTRODUCTION TO ICD

The International Classification of Diseases (ICD) is “a classification system developed collaboratively between the World Health Organization (WHO) and [ten] international centers so that medical terms reported by physicians...can be grouped together for statistical purposes.”⁴

The purpose of the ICD and the involvement of the WHO is “to promote international comparability in the collection, classification, processing, and presentation of mortality statistics.”⁵ The goal is to have a consistent and standardized coding system around the world in order to improve data collection and compare medical statistics with different countries. Coding is an essential part of the medical field in the United States because in order to be reimbursed, a physician is required to submit a claim to Medicare using a specific set of numeric codes that describe the medical reasons for treatment and the treatment itself.⁶

Since the 1980’s, physicians in the United States used an adaptation of ICD, called ICD-9, for reporting “diagnoses, injuries, impairments and other health problems and their manifestations, and causes of injury, disease, impairment or other health problems in standard transactions.”⁷ As medicine rapidly advanced, it became challenging to capture health care changes with ICD-9; therefore, most industrialized countries transitioned from ICD-9 to ICD-10.

⁴ Dep’t of Health & Human Servs. et al., *International Classification of Diseases Tenth Revision (ICD-10)*, 1, 1 (2001), <http://www.cdc.gov/nchs/data/dvs/icd10fct.pdf>.

⁵ *Id.* at 1-2.

⁶ Timothy D. Martin, *The Impact of Healthcare Reform on Revenue-Cycle Management & Claim Coding*, 4 J. Health & Life Sci. L. 159, 176 (2011).

⁷ HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS, 74 *Fed. Reg.* 3328, 3329 (Jan. 16, 2009) (to be codified at 45 C.F.R. pt. 162).

ICD-9 was outdated and its “approximately 16,000 procedure and diagnosis codes [we]re insufficient to continue to allow for the addition of new codes, and because it [could] not accommodate new procedures, its capacity as a fully functioning code set [wa]s diminished.”⁸ With the challenge of capturing the advancement of medicine with ICD-9, ICD-10 became the awaited solution to the outdated coding system.

The WHO began working on ICD-10 in 1983 in order to provide “specific diagnosis and treatment information that can improve quality measurements and patient safety, and the evaluation of medical process and outcomes.”⁹ ICD-10 CM/PS consists of the following two parts: (1) diagnosis coding (ICD-10-CM) developed by the Centers for Disease Control and Prevention (CDC) for use in all health care settings in the United States and (2) inpatient procedure coding (ICD-10-PS) developed by the Centers for Medicare and Medicaid Services (CMS) for use in inpatient hospital settings.¹⁰

1. ICD-9 Versus ICD-10

The major difference between ICD-9 and ICD-10 coding is the specificity of information provided in a single code. For example, ICD-9 required the following two codes for a pressure ulcer: one code to indicate the ulcer’s location and the other to indicate the ulcer’s severity; whereas, ICD-10 requires one code to indicate both the location and severity of the pressure ulcer.¹¹ ICD-9 was more user-friendly because it contained up to five digits in its code; whereas, ICD-10 “utilizes codes of up to seven alphanumeric characters to identify disease categories,

⁸ *Id.* at 3330.

⁹ *Id.*

¹⁰ *ICD-10 Fact Sheet: Basics for Small & Rural Practices*, Ctrs. for Medicare & Medicaid Servs., 1, 3 (Aug. 2014), http://www.cms.gov/eHealth/downloads/eHealthU_BasicsSmallRuralPrac.pdf.

¹¹ Peter J. Carpentier, *The Risk of Getting Paid: Why ICD-10-CM May Increase Physician Liability under the False Claims Act*, 16 *Quinnipiac Health L.J.* 117, 126 (2013).

etiologies, affected body parts, illness severity, and additional factors to increase specificity and data precision.”¹² Thus, ICD-10 introduces additional and complex diagnosis details that only the physician knows based on what happened in the exam room. Another difference between the two systems is that ICD-9 had about 14,000 diagnosis codes and ICD-10 has 69,000 codes to “better capture specificity.”¹³ However, there has been some criticism of ICD-10 increasing the proliferation of codes to an absurd degree, such as ICD-9 containing one code for angioplasty, while ICD-10 contains over 850.¹⁴

In order to achieve compliance and a smooth transition from ICD-9 to ICD-10, the Centers for Medicare and Medicaid Services (CMS) has developed two types of maps. First, General Equivalence Mappings (GEMs), also known as forward and backward maps (ICD-9 to ICD-10 and ICD-10 to ICD-9), which include “all possible ICD-10 code translation alternatives for each code in ICD-9.”¹⁵ Second, Reimbursement Mappings offer a “single recommended mapping of each ICD-10 code (both diagnoses and procedures) back to a single ICD-9-CM code.”¹⁶ The maps are intended to be used by physicians when converting the ICD-10 codes to more familiar ICD-9 codes in order to help physicians understand the new coding system and avoid severe penalties for improper claims under the FCA.

¹² *International Classification of Diseases, (ICD-10-CM/PCS) Transition-Background*, Ctr. for Disease Control & Prevention (Oct. 1, 2015), http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm.

¹³ *Road to 10: The Small Physician Practice’s Route to ICD-10*, Ctrs. for Medicare & Medicaid Servs., (2015), <http://www.roadto10.org/whats-different/>.

¹⁴ Neil Issar, *More Data Mining for Medical Misrepresentation? Admissibility of Statistical Proof Derived from Predictive Methods of Detecting Medical Reimbursement Fraud*, 42 N. Ky. L. Rev. 341, 348-49 (2015).

¹⁵ Valerie A. Rinkle & Catherine M. Boerner, *ICD-10 & Compliance-Joined at the Right Hip Osg90zz? Key Aspects of ICD Coding & How It Impacts Operations, Payment, & Reputation Capital*, 15 J. Health Care Compliance 5, 9-10 (2013).

¹⁶ *Id.* at 10.

2. The False Claims Act

Improper claims occur when “a physician is reimbursed for claims that should have been rejected, but due either to unintentional oversight or to intentional fraud, the physician is paid for the services that he claims to have provided.”¹⁷ Due to the specificity and high level of detail in ICD-10 codes, physicians are responsible for the code assignments on their diagnoses and procedures, which gives providers an opportunity to charge for additional services in order to increase reimbursement, also known as upcoding.¹⁸ In an attempt to deter physicians from upcoding, the government passed a federal statute, the FCA, in order to prosecute individuals who defraud the government by seeking payment for false or fraudulent claims.¹⁹ Any person is liable who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”²⁰ Also, any person is liable who “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”²¹

The FCA defines the terms “knowing” and “knowingly,” which both mean that “a person, with respect to information, - (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.”²² Further, the Act states that no specific intent to commit fraud is required, which allows the government to prosecute a broad range of conduct when the definition of “knowingly” is applied to the acts.²³

¹⁷ Carpentier, *supra* note 11, at 129.

¹⁸ Leemore Dafny & David Dranove, *Regulatory Exploitation and Management Changes: Upcoding In The Hospital Industry*, 52 J.L. & Econ. 223, 224 (2009).

¹⁹ 31 U.S.C. § 3729(a) (2010).

²⁰ *Id.* at § 3729(a)(1)(A).

²¹ *Id.* at § 3729(a)(1)(B).

²² *Id.* at § 3729(b)(1).

²³ *Id.* at § 3729(b)(1)(B).

The government is “cracking down” on coding fraud committed under HIPAA in order to deter future violations and to recover monetary penalties. CMS recovered over \$400 million dollars in 2012 for fraudulently billed services.²⁴ As Medicare and Medicaid funding has increased for healthcare services, there has been a corresponding increase of false claims and FCA cases. In a span of fifteen years, \$30 billion dollars were recovered by the government for FCA violations.²⁵ As a result, there is a significant monetary incentive for the government to continue to detect any violations under the FCA.

II. THE IMPACT OF ICD-10 ON PHYSICIAN LIABILITY

The transition from ICD-9 to ICD-10 will have a significant impact on physician liability under the FCA. First, ICD-10 codes are more complex and specific than ICD-9 codes because they contain more alphanumeric digits, which increases the chances of error. The government can prosecute physicians for not providing valid codes by claiming the physicians had a reckless disregard of the truth of the claim. Second, the convoluted codes in these two code sets have complex mappings making the transition from ICD-9 to ICD-10 difficult, especially for private practice physicians who are relying on the mappings tool when reporting their codes. These unreliable mappings can lead to errors in coding and increase the physician’s liability for upcoding. Third, CMS’s reliance on post-payment review is problematic because the addition of new codes will likely increase the probability of coding errors and physicians will not be able to detect these errors in time and will be held liable for claim and coding inaccuracies. Fourth, problems with claim resubmission increase physician liability because the updated coding

²⁴ Scott D. Lifchez, *Ethical and Educational Considerations in Coding Hand Surgeries*, 39 J. Hand. Surg. Am. 1370, 1370 (2014).

²⁵ Lonie Kim, *Am I Liable? The Problem of Defining Falsity Under the False Claims Act*, 39 Am. J. L. & Med. 160, 161 (2013).

system lacks codes for secondary diagnoses. Lastly, the timing and cost of the ICD-10 transition impacts private practice physicians more than it does large practices and hospitals because independent physicians have less resources to transition successfully without any coding errors. Private practice physicians may not have the resources for a smooth transition because they may not have employees who submit bills or they may not have the necessary training on the updated coding system. Physicians operating private practices must spend time coding in order to get paid for their services while also avoiding the risk of severe penalties for submitting erroneous and improper claims and codes.

1. Highly Complex and Specific Codes

As mentioned previously, ICD-10 coding contains up to seven alphanumeric digits; whereas, ICD-9 coding contained up to five digits. ICD-10 contains more detail and more codes to choose from than ICD-9 because it provides all the information in one code as opposed to two separate codes. As a result, the increased length and attention to detail with each code increases the chances of error. Since physicians are the ones who select the code, it is likely that they will be accused of having “actual knowledge” of the code or for acting in “reckless disregard of the truth or falsity of the information.”²⁶ Even if the physician does not submit the codes, he will still be liable as seen in *United States v. Krizek*, where a physician was liable for upcoding even though his secretary maintained and submitted the billing codes.²⁷ Basically, “if the physician does not make sure that the claim and codes contained in the billing record are correct, then the physician remains liable under the FCA for acting in reckless disregard of the truth or falsity of the claim.”²⁸

²⁶ 31 U.S.C. § 3729(b)(1)-(3).

²⁷ *United States v. Krizek*, 111 F.3d 934, 936 (D.C. Cir. 1997).

²⁸ *Carpentier*, *supra* note 11, at 139.

In addition, there is no intent requirement when proving violations of the FCA, which makes it harder for the physicians to argue against these claims. The complexity and specificity required by ICD-10 “will make it easier to show that a physician has ‘knowingly’ selected the wrong code.”²⁹ The transition to the ICD-10 system has the advantage of “more detailed diagnosis coding than is possible with ICD-9 and room for expansion of codes; however, in counterbalance, the greater numbers of codes may increase the difficulty for the clinical coders in their efforts to maintain coding accuracy.”³⁰ Thus, private practice physicians will have an “uphill battle” when fighting FCA cases because it will be difficult for them to prove they were not being reckless when they used improper codes.

The increased number of codes as well as the complexity and specificity of ICD-10 coding leads to a lack of unanimity among health care providers and professional coders. Due to the proliferation of codes in the ICD-10 system, there are numerous codes for the same diagnosis and treatment. As mentioned above, ICD-9 contained one code for angioplasty; whereas, ICD-10 contains over 850 for the same code. The proliferation of codes is problematic as the United States health care system transitions to the most recent coding system because there are disagreements as to which code to use for the same diagnosis. Physicians and professional coders are using different codes to transcribe the same information on diagnosis and treatment, which leads to a lack of unanimity. A lack of unanimity is problematic since the purpose of ICD-10 coding is to promote a global perspective on medical statistics and provide comparable data. With a lack of unanimity in coding among both health care providers and professional coders,

²⁹ *Id.* at 138.

³⁰ Toni Henderson et al., *Quality of Diagnosis and Procedure Coding in ICD-10 Administrative Data*, 44 *Medical Care* 1011, 1011 (2016).

there is likely to be an increase in inadvertent coding error or fraudulent coding activity such as upcoding.³¹

2. Convoluted Codes and Complex Mapping

To prevent physicians from providing erroneous codes and to aid in the ICD-10 transition, CMS created an ICD-10 mapping tool, which allows physicians to translate ICD-9 codes into ICD-10 codes and vice versa. However, this tool presents some challenges, especially since these two sets of convoluted codes have complex mappings. For instances, there are 255 instances where a single ICD-9 code can map to more than fifty ICD-10 codes, and 119 instances where a single ICD-9 code can map to more than 100 ICD-10 codes.³² These convoluted codes have complex mappings, thus, making the transition from ICD-9 to ICD-10 difficult because physicians are unable to receive clear translations between these two distinct coding systems.³³

One study analyzed over 2,700 diagnosis codes and found that twenty-six percent of all pediatric ICD-9-CM codes were associated with convoluted codes.³⁴ The study found that “of the 636 convoluted codes analyzed by pediatricians for accuracy, nearly forty percent were categorized into the following three categories: information loss (fourteen percent), overlapping categories (eighteen percent), or inconsistent categories (seven percent).”³⁵ The study found that the convoluted codes “have the potential to cause inaccuracies during the transition to ICD-10-CM, which may lead to adverse consequences, including financial loss from billing errors, errors

³¹ Issar, *supra* note 14, at 374.

³² John Wollman, *ICD-10: A Master Data Challenge*, 32 Health Mgmt. Tech. 16, 16 (2011).

³³ Richard Caskey, *The Transition to ICD-10-CM: Challenges for Pediatric Practice*, 134 Pediatrics 1, 33 (2014).

³⁴ *Id.* at 32.

³⁵ *Id.* at 33.

in surveillance, and inaccurate administrative data.”³⁶ Consequently, physicians will be held liable for providing erroneous codes even if they relied on these mappings.

3. Post-Payment Review Implications

Liability will not be reduced for private practice physicians after the transition to ICD-10 because CMS will rely on the post-payment review of claims to identify erroneous payments. Under a post-payment review system, claims have already been processed and paid. Before the billing codes are reviewed, physicians have to rely on their coding ability and internal audits if they hope to avoid the severe penalties for any FCA violations.³⁷ Reliance on post-payment review is problematic because the addition of 68,000 new codes will “likely increase the probability of coding errors on claims submitted to Medicare.”³⁸ Physicians will be held liable for upcoding even if they made honest mistakes prior to the post-payment review.

4. Lack of Claim Resubmission

Another issue with the transition from ICD-9 to ICD-10 is the lack of claim resubmission. With the ICD-9 coding system, physicians were able to resubmit codes after their claim was rejected and they could resubmit secondary diagnoses. However, with ICD-10, there is one code and the “selection of a new code, especially after deliberate selection of a code that the physician thought supported his diagnosis, could arguably be seen as meeting the ‘knowingly’ standard if that claim results in an overpayment.”³⁹ Problematically, private practice physicians will be held liable for “knowingly” upcoding even if they were just trying to resubmit claims with secondary diagnoses.

³⁶ *Id.* at 34.

³⁷ Carpentier, *supra* note 11, at 139-40.

³⁸ *Id.* at 140.

³⁹ *Id.* at 141.

5. Timing and Costs Associated with the Transition

The timing of the ICD-10 transition is problematic because physicians are “spending significant financial and administrative resources implementing health records in their practices and trying to comply with multiple quality and health information technology programs that include penalties for noncompliance.”⁴⁰ Private practice physicians are ensuring they remain compliant with new healthcare regulations while also transitioning to a new coding system. Most small practices do not have the financial resources such as the staff, technology, and budgets to make the transition from ICD-9 to ICD-10. The implementation of ICD-10 is expensive because “the cost for individual physician practices to adopt ICD-10 is estimated to be around \$83,000.”⁴¹ The significant cost and bad timing of the transition makes it more likely that physicians will be unable to comply with this transition and they will be held liable for violating the FCA by upcoding and seeking improper payments.

III. THE “SO WHAT” WITH THE TRANSITION TO ICD-10 CODING

As the health care system in the United States transitions to ICD-10, the increased liability on physicians is alarming because it disincentives them from opening private practices out of fear of high penalties under the FCA for erroneous claims and codes. The decrease in private practice physicians leads to several disadvantages in health care such as lack of competition, increase in the cost of health services, and fewer longstanding relationships between patients and physicians. With a decrease in private practices, hospitals are becoming the sole provider for health care needs. Thus, there is a lack of competition in the market because patients no longer have a choice between private care and hospital care. Without competition, the costs of

⁴⁰ *Id.* at 142.

⁴¹ *Id.* at 143.

health care services increase because hospitals become monopolies and patients are left with no choice to “shop around.” Also, with more patients entering hospitals, physicians have less time to spend with patients and the relationship between the physician and the patient is diminished.

The health care market has seen an increase in market consolidation with the increase in costs and administrative burdens. The increase of mergers could eventually create big hospital systems, which may drive up costs. As this consolidation continues, “hospitals fiercely holding onto their independence may find it more difficult to compete against bigger, leaner organizations.”⁴² In addition, increased market consolidation will be another consequence of ICD-10 implementation because independent physicians will find it harder to remain independent.

In order to prevent the increased liability on private practice physicians, medical students and doctors must form a coalition around this issue and gain the attention and interest of the public in order to build momentum. The coalition between the medical students and doctors is crucial because the doctors can advocate for change by helping the medical students understand the current situation with the inadequate training and education with coding. In the meantime, medical students will have mentors in the field and they can advocate for change in their medical schools. Medical schools have an interest to comply with student recommendations because they want to remain competitive in the market.

Most doctors enter the medical field because they want to help others; therefore, this movement can gain their attention, especially since it affects their career opportunities. Medical school graduates are almost forced to find employment at a hospital because they do not want the

⁴² Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, THE NEW YORK TIMES (Aug. 12, 2013), http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?pagewanted=all&_r=0.

added risk of penalties for improper claims and codes. Despite the importance of coding and billing, physicians spend little time teaching or learning about billing either during residency training or after starting their own practices.⁴³ Thus, physicians have little to no experience with coding.

According to *Medical Schools to Replace Curriculum with Year-Long Course in ICD-10 and E&M Coding*, the deans of the top medical schools in the United States “are replacing their schools’ entire 3rd-year curriculum with an intensive year-long course on diagnostic and evaluation and management coding.”⁴⁴ The reason for this decision was triggered by the “realization that coding is central to a physician’s work day, with estimates that it comprises up to 50% of their professional time.”⁴⁵ Thus, there is already a movement to help medical students gain the expertise in coding since it comprises half of their work day. Now, the need is to push more medical schools nationwide to implement such curriculum in order to prepare medical students for their “real world experience” as doctors.

The biggest issue with forming a nationwide coalition is gaining the interest and attention of the general population. For the most part, people are indifferent to various issues and they will not fight for a cause unless it directly impacts them. For this reason, the coalition must gain public attention by indicating how an increase in private practice physician liability impacts them directly in terms of quality of care and the costs associated with such care.

The name of the coalition would be “A Day Without Private Practice Physicians.” Each patient visiting a private practice physician would receive a flyer with the name of the coalition,

⁴³ Lifchez, *supra* note 24.

⁴⁴ Gomerblog Team, *Medical Schools to Replace Curriculum with Year-Long Course in ICD-10 and E&M Coding*, GomerBlog, at ¶1, available at <http://gomerblog.com/2014/11/top-medical-schools/>.

⁴⁵ *Id.* at ¶ 2.

quick bullet points on the issue of increased liability for private practice physicians under the FCA, and an explanation of how this issue directly impacts them. The flyer would explain how the issue goes beyond just a transition from ICD-9 to ICD-10 and how it arises from the penalties under the FCA. Further, the flyer would explain how the increased liability on private physicians is created with the broad definition of “knowingly” under the FCA and how intent need not be proven in order to penalize physicians for providing an erroneous claim or code. The flyer would also include phone numbers to local political representatives so patients could call and have their voices heard. Since most people are unmotivated to call and get involved politically, the patients would have an option of just signing a postcard while waiting to see their physician. The pre-addressed postcard to their political representatives would ask their representatives to inflict some changes to the FCA.

The main objective of “A Day Without Private Practice Physicians” would be to push legislators to amend the FCA’s “knowledge” requirement by limiting enforcement against physicians only if it can be shown that the physician “has actual knowledge of the information” or “acts in deliberate indifference of the truth or falsity of the information.” This change is crucial to limiting the liability of private practice physician under FCA because physicians could no longer be charged for violations without the proof of intent. Physicians should be penalized under the FCA only if it can be shown that the physician has “actual knowledge” of the information or “acts in deliberate indifference of the truth or falsity of the information.” Physicians can make mistakes when coding, especially with a new coding system that is more complex than the previous one. Physicians who abuse the coding system should be penalized; however, it should be recognized that not all mistakes are made with the intent to fraud the

government. In order to change the FCA and dispose of the no requirement to show intent, there needs to be a strong push from medical lobbyist groups.

The coalition can also fight for a solution to this problem by pushing policymakers to implement legislation stating that “for at least two years following the implementation of ICD-10, the harsh penalties of the FCA should not be imposed on a physician unless that physician has acted in manner beyond reckless disregard of the truth or falsity of the claim she has submitted.”⁴⁶

In order to receive enough finances to provide flyers and postcards for such a large campaign, the coalition would need to gain endorsers. While it may be difficult to find endorsers, various fundraisers such as 5Ks, auctions, raffles, galas, and other events can give the coalition a financial start as well as recognition. After the coalition gains momentum, endorsers, and funding, it can hire lobbyists to advocate for private practice physicians.

Lobbyists are successful at implementing change in this country because they have the power to persuade decision makers. Generally, policymakers are responsive to civil society organizations, coalitions, and lobbyists “since they are reliant on the public for re-election and organized interests represent citizen interests.”⁴⁷ Thus, democratic accountability of a political system has an impact on the level of lobbying success because the goal of politicians is to get reelected. Politicians are always campaigning and will not take the risk of losing an election by fighting a strong movement.

The “A Day Without Private Practice Physicians” lobbyists will seek bipartisan support because both Democrats and Republicans can agree that an alternative healthcare plan is needed

⁴⁶ Carpentier, *supra* note 11, at 148.

⁴⁷ Christine Mahoney, *Lobbying Success in the U.S. & E.U.*, 27 J. Pub. Pol’y 35, 38 (2007).

to help improve affordability and coverage options for all Americans.⁴⁸ Both political sides can be addressed because Democrats seek to increase the access of health care to more individuals and Republicans seek to improve the quality of care. The coalition would address the concerns of both political parties in order to gain bipartisanship and more support on Capitol Hill. The coalition should encourage Congress to improve medical reimbursement by delinking the ICD system from the reimbursement policy and establishing a new reimbursement process that makes the billing process less burdensome.⁴⁹

The lobbyists should also put pressure on CMS and demand answers from them on the effects of transitioning to ICD-10.

In its final rule on ICD-10, CMS acknowledged providers' fears that liability would remain the same or increase as a result of the change to ICD-10; however, CMS's response to these concerns did not provide a clear answer. Commentators had the opportunity to raise their concerns and one commentator noted "that during the transition from ICD-9 to ICD-10, provider coding errors should not be used as a basis for prosecution under the False Claims Act." CMS responded to these comments stating, "we will take these comments under consideration and inform the industry and other interested stakeholders through normal CMS communication channels of any decisions made relative to these issues." This concern appears to be the only one referenced in the final rule to which the CMS did not respond with a direct answer or explanation.⁵⁰

Consequently, CMS is not taking concerns seriously even though the commentators raised legitimate and important questions and fears of increased liability for physicians. Physicians should be disappointed with a federal agency that does not listen to their concerns and so the movement should gain momentum.

⁴⁸ CTU Faculty, *Conservatives v. Liberal Healthcare Viewpoints*, Colorado Technical University (Sep. 11, 2012), <http://www.coloradotech.edu/resources/blogs/september-2012/conservative-liberal-healthcare>.

⁴⁹ John Grimsley & John O'Shea, *The New Disease Classification (ICD-10): Doctors and Patients Will Pay* (May 18, 2015), http://www.heritage.org/health-care-reform/report/the-new-disease-classification-icd-10-doctors-and-patients-will-pay#_ftnref43.

⁵⁰ Carpentier, *supra* note 11, at 138.

If “A Day Without Private Practice Physicians” fails to gain momentum on a large scale, then it is time to educate medical students on coding and billing in order to prevent future errors and FCA violations. Despite the importance of coding and billing, physicians spend little time learning about billing either during residency training or after starting their own practices.⁵¹ Although resident physicians spend three or more years during residency, and often additional years during fellowship, acquiring clinical decision-making and technical skills, little to none of the training focuses on medical coding.⁵² The lack of coding training is problematic because physicians are not familiar with coding; therefore, they make coding errors. In order to avoid FCA violations, coding training is necessary and must be implemented into medical school curriculums. Even though some of the top medical schools already implemented coding curriculums, this curriculum must be implemented in all medical schools in order to have a significant impact in the health care system.

Most importantly, private physicians should be provided a mentorship program post-medical school in order to deal with the current lack of training with ICD-10 codes. The mentorship program should be mandatory as a required Continuing Medical Education (CME) course in order to educate and train current private physicians on coding. Training is crucial and one of the most important solutions in this area because it ensures private physicians become familiar with effective coding and billing practices; therefore, decreasing their liability under the FCA. The importance of billing and coding training is highlighted by the American Academy of Family Physicians (AAFP), which offered an ICD-10 webcast titled “Increased Specificity Paves the Way for Increase Reimbursement.” The webcast was offered to physicians to assist their

⁵¹ Lifchez, *supra* note 24.

⁵² *Id.* at 1373.

practice with accurately understanding the ICD-10 coding system and how to appropriately code the severity of illnesses of patients. Thus, the importance of training is emphasized through all the webinars and training programs offered for physicians because this stresses its importance and relevance in the health care industry.

IV. ICD-10 CODING GLITCH

Due to an ICD-10 glitch based on an update to diagnosis and procedure codes, CMS issued “a get-out-of-Medicare-penalties-free-card for two years to physicians and group practices.”⁵³ Thus, CMS will not apply 2017 and 2018 payment adjustments to physicians who fail to “satisfactorily report for (calendar year) 2016 solely as a result of the impact of ICD-10 code updates on quality data reported for the 4th quarter of (CY) 2016.”⁵⁴ Since certain problem areas were identified in the ICD-10 coding systems, CMS does not want to penalize providers for these glitches. More research must be done in order to determine how CMS actually handled these situations and whether any payment adjustments were applied.

As medicine advances and new diseases emerge, how will the ICD-10 coding system adapt to these changes? Will CMS not hold private practice physicians liable for glitches in the system when problem areas are identified? These unanswered questions raise several concerns for private practice physicians and more research is required in order to understand how the transition has affected and will continue to affect private practice physicians.

As technology progresses, the anticipation is that private physicians will have more technological resources to provide quality health care to patients. Pulse8, a healthcare analytics

⁵³ Joseph Conn, *ICD-10 glitch leads CMS to relax physician quality penalties*, MODERN HEALTHCARE (Jan. 9, 2017), <http://www.modernhealthcare.com/article/20170109/NEWS/170109911>.

⁵⁴ *Id.*

company, is “offering a tool to identify and code patient conditions by accessing content from their clinical data.”⁵⁵ These technological advances raise new liability concerns and raise the question of who will be liable for improper coding once private practice physicians implement these coding software systems. Additionally, even if the technology is available, will it be affordable for private practice physicians or will these technologies only widen the disparities between hospitals and private practice facilities? Again, these unanswered questions continue to raise concerns for private practice physicians because the uncertainty as to their potential liability likely deters physicians from opening a private practice.

In conclusion, even though the transition to ICD-10 coding is important for promoting value-based payment and increasing the quality of health care overall in the U.S., the new system is problematic for private practice physicians because it increases their liability under the FCA with improper claims and codes. Under the FCA, the government has broad discretion to prosecute conduct that could easily fit the definition of “knowingly.” In order to prevent the decline of private practice physicians, health care professionals should start a movement and lobby political representatives for changes to the FCA to narrow the scope of liability faced by physicians for innocent coding mistakes. In addition, current and future private practice physicians should receive adequate education and training in billing and coding in order to improve the accuracy of ICD-10 coding in private practice.

⁵⁵ Jack McCarthy, *Pulse8 unveils machine learning for ICD-10*, HEALTHCARE IT NEWS (Dec. 20, 2016), <http://www.healthcareitnews.com/news/pulse8-unveils-machine-learning-icd-10>.