Strategic ICD-10: Five Things to Know

The Switchover to ICD-10 is Now a Fait Accompli.

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Several months into the ICD-10 transition, providers have yet to experience any of the Y2K-like glitches that were widely predicted to bring their revenue cycles to a halt. In fact, a Physicians Practice survey[1] revealed that 47.3 percent of readers say they are not experiencing problems with the ICD-10 transition and claims are being rejected at the same rate prior to the coding shift. That is impressive given that the changeover from ICD-9 to ICD-10 is one of the most significant updates to the U.S. healthcare system in more than 30 years.

The initial work of ICD-10 transition is complete; Providers must now plan for the long-term where ongoing staff training, physician relations and network-wide communications take center stage in the effort to mitigate reimbursement impacts under the ICD-10 coding system.

"Understandably, provider organizations must prioritize other commitments, but health information management leaders cannot take their eyes off of the requirements to support ongoing coding excellence across the enterprise," says Lana Cabral, enterprise leader for ICD-10 at Conifer Health Solutions. As ICD-10 coding is steadily integrated into daily workflow—including electronic medical records and billing systems—Cabral says any gaps in process or communications could result in an increase in technical and clinical denials.

Here are five recommendations to avoid unnecessary impacts to cash flow:

1. PARTNER WITH PHYSICIANS TO PROMOTE SPECIFICITY

One of the determinants of whether or not an optimal and appropriate level of reimbursement is possible is the degree of diagnostic specificity contained in physicians' notes. Under ICD-10, a well-documented case, replete with all the correct diagnostic codes, adds even more time to the physician's routines outside of patient care. Providers should assist employed and aligned physician practices alike to adopt best practices for coding and documentation. Monthly webinars or lunch-n-learns can work to engage physician

offices in ongoing dialogue to promote effective health information management practices. In the interim, medical staff may have to run down the missing data. However, an insufficient claim results in delayed payment, so time spent gathering the detail to properly build a claim is well spent.

2. ENLIST PATIENT REGISTRATION TO PINPOINT TROUBLE SPOTS

Patient Registration is one of the lynchpins in the revenue cycle given the patient access representatives' role in collecting demographic data, validating coverage and collecting payment. Registration staff is also responsible for reviewing physician order authorizations and related diagnosis codes for completeness. With ICD-10, this function is more crucial than ever. A less-than-thorough triage may cause patients to be assigned a lower acuity and potentially be denied a test, procedure or operation because the payer doesn't receive sufficient information to understand the need.

"If the complexity is not properly documented, it can significantly impact approvals," Cabral says. For instance, if a patient needs a PET scan but the diagnosis code lacks specificity, the insurer may green-light other less costly procedures first, inadvertently delaying delivery of more urgent care. Or if a provider goes forward with a procedure without a pre-certification, the organization could face a technical denial when the claim is submitted. Patient registration is one of the first lines of defense to prevent such occurrences.

3. HAVE CODERS HONE IN ON DOCUMENTATION

In terms of proper treatment and reimbursements, population health management is a critical requirement for success under the Affordable Care Act. Documentation must be precise. Incomplete documentation and imprecise coding can affect a physician's quality measures. For instance, the complexity of a patient's diagnosis can only be understood by the co-morbidities included in the diagnostic coding. If these co-morbidities are undocumented, determining proper treatment becomes problematic for the physician, or can cost medical staff time on follow-up queries. Clear documentation with proper coding ensures accurate assessment of a physician's quality level and population health as well as increased efficiency of medical staff.

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4. UNDERSTAND EVERY PAYER'S ICD-10 STATUS

While virtually every care provider prepared for ICD-10, only about half of workers' compensation practitioners were ready to make the transition by the October 1, 2015 deadline, according to the Workgroup for Electronic Data Interchange (WEDI).[2] Property & Casualty practitioners were similarly situated[3] during that same period. This patchwork of payer practices will likely persist for the foreseeable future, bringing with it the propensity for confusion and incorrect reimbursement.

Providers must understand the status and practices of each payer, particularly those that are out of network. Further, if the claims submission ecosystem still includes the need for dual coding for particular payers, the added layer of complexity can slow reimbursements and increase the appeals workload.

5. BE READY FOR DENIALS AND APPEALS

Notwithstanding early analysis of ICD-10 coded claims, the potential for increased denials and appeals will remain on the horizon. When CMS' window for coding flexibility comes to an end on October 1, 2016[4], those who have yet to incorporate coding specificity into their routine will likely be the most impacted by denials.

A breakdown in processes, training or communication at any point along the continuum of care can spark a chain reaction that has the potential to adversely impact your organization's pursuit of an efficient and high-performing revenue cycle. Until all stakeholders of the healthcare ecosystem have accepted and integrated ICD-10, providers should stay vigilant about the chances for increases in denials and appeals. How big that increase will be depends on your organization's application of ongoing ICD-10 best practices.

Mastering the foundations of risk and working with a trusted partner can help providers capture the whole healthcare dollar faster and more effectively, without the burden of becoming an expert in the business of health plans.

At Conifer Health, we help our clients turn ICD-10 to their organizations' advantage. Learn more at ConiferHealth.com. ■

[1] Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-29.html.
[2, 4] Source: http://www.wedi.org/knowledge-center/resource-view/resources/2015/09/03/property-and-casualty-icd-10-state-readiness-resource-center
[3] Source: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf.