ICD-10 Has Arrived…Now What?

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The long-awaited transition from ICD-9 to ICD-10 finally took place on October 1, 2015, and you may be wondering as a provider or administrator what you should be doing in your practice now.

In the months leading up to the transition date you were probably informed to do the following: Crosswalk your top 25-50 diagnosis codes, take steps to improve clinical documentation, make sure revenue cycle staff has adequate training, make sure you have enough cash on hand to cover expenses, and most importantly, make sure that your billing software and clearinghouse are ICD-10 ready. If you have taken the time to do all of those things, you probably consider your practice to be in pretty good shape and you probably are. With all those things being said, however, there is still more work to be done.

There is probably a sense of relief among providers, clinical support staff, and revenue cycle staff everywhere, but we are still in the land of the unknown. We should all keep focused on the following:

• Am I doing everything in my power to help cash flow?
• Is my documentation and coding to the highest specificity possible?
• Will I understand and know how to process the various denial reasons?
• Is there a delay in the processing of claims?
• Should I be conducting ongoing chart audits?

Surviving the last quarter of 2015 may not be an easy task for some practices as it pertains to cash flow. It is important that the patient registration process is ironclad. Obtaining complete and accurate demographic information along with complete and accurate insurance information are important. It is very beneficial for a practice to verify insurance prior to the patient's appointment time so the front desk staff can be prepared to collect copays, deductible amounts, and any outstanding balances owed. It will also be beneficial for practices to avoid huge cash expenditures during the last quarter of 2015 to help maintain cash flow.

Before claims are sent out the door it is a good idea to have a coder take a second look to see if there is any missing documentation and the claim is coded using the highest specificity. CMS announced that claims will not be denied for level of specificity for 12 months after the ICD-10 transition date, but that does not mean that other payers won’t. Coders and providers should have open lines of communication during this time so that there is not a delay in the billing process. It may also be advantageous for a practice to nominate a “Physician Champion” for ICD-10 for peer-to-peer education.

Denial management is another key component that practices should pay attention to. It is important to do thorough research when a claim is denied for ICD-10. If the denial reason is not clear, it is imperative that someone from your billing department calls the payer to get clarification on what is needed in order to correct the claim. Denials can be used to train physicians and clinical support staff on documentation and coding requirements. It is also important to look at the big picture when it comes to denials to see if trends and root causes can be identified. All denials should be addressed immediately to prevent future denials that can and will impact cash flow.

Accounts Receivable management should also be a focus point for your practice's billing department. Once claims submission has taken place it is important to confirm that the number of claims you submitted were accepted by the clearinghouse and the payer. If a claim falls out and does not go through the submission process successfully, it should be due to a claims edit that was created and should be reviewed immediately. Claim acceptance can be verified by using the EDI report (Claim Status), which can be obtained from your clearinghouse. Ohio has a prompt pay law, meaning you should know if a claim is being denied or paid within 15-30 days. Best practice is for the A/R team to start calling on claims between 20-30 days. This practice will also serve as a double check to confirm that the payer has the claim on file, which in turn will help the practice avoid timely filing denials.

It is also important for practices to perform ongoing chart audits to ensure that all billing providers are using the correct ICD-10 codes. All chart audits should be performed by a Certified Professional Coder that has had ICD-10 training. Feedback and education should always be a part of the audit process. Documentation of the audit findings and provider education should be kept on file for reference in the future.

The world of healthcare is ever-changing, or I should say the requirements put on providers by CMS and the government are ever-changing. With all of the new healthcare requirements and guidelines, it is imperative that physicians and support staff form a partnership with one goal in mind — to provide the best patient care possible while meeting CMS requirements. ICD-10 requires a more collaborative effort with patients due to the level of detail that we need to obtain from them. At the beginning this will require patient education on why this type of detailed information is needed. The one thing that will never change is that this world will always need physicians to facilitate and guide patients through their medical journey and on to a healthier life…welcome to the world of ICD-10.