ARTICLE SUBMISSION - COMPLIANCE TODAY –

Article Word Count (1,398)

Cracking the ICD-10 Code to Stay Compliant: Meeting the Challenge

The International Classification of Diseases (ICD)-10 coding system, replacing the decades-old ICD-9 coding system with 141,000 new diagnosis and procedure codes and definitions, went into effect October 1, 2015. After several postponements, the new clinical diagnostic and procedural codes are in place and the question now becomes, "how are we doing?"

Are we Compliant?

For the most part, providers and other key stakeholders have continued to move along without too much anxiety or disruption post ICD-10 conversion. With such a significant change, some might wonder if there should be more concern. Others just assume organizations did such a great job of preparing for the ICD-10 challenges that most providers are compliant.

Unfortunately, while some providers may be at a different level of preparedness and acceptance than their peers, the reality is most will not know how well their organization or practice is complying with ICD-10 until several months down the road.

What Are the Top Compliance Issues Likely to Be?

As the last developed nation to adopt ICD-10, and the only one in the world who relies on these codes for reimbursement, the U.S. is implementing a modification that is vastly more granular and specific than any of our contemporaries. Just as you have probably spent the last year educating, training and testing your staff and systems for the transition, the next six months will be crucial to meeting compliance milestones by closely monitoring your providers, coders, billing services, claims scrubbers and clearinghouses. Here is what you need to know:

- **Finding the appropriate ICD-10 code can be difficult if search tools are not logical or as intuitive as busy providers may need.** Additional education post ICD-10 may be needed for your providers sooner than later before issues escalate.

- **Lack of code specificity may result in claims rejections.** The new ICD-10 coding convention has gone from a 3-5 character composition to 3-7 characters. Because of the changes in the ICD-10 code structure and definitions, the new level of detail will require greater specificity and, in some cases, different documentation for care provided. *You need a good internal edit resolution and denial management process in place.*

- **Coders will need greater connectivity with physician resources.** As coders learn the new ICD-10 language, they will need greater access to and alignment with physician resources and clinical documentation processes.

- **Erroneously entered codes can slip through the cracks.** In some environments, professional coding resources may not code or review all codes assigned by providers. Unless your EMR and/or billing systems have the sophistication and functionality to trigger an edit following a

physician entry, you will run the risk that a coding resource may never touch the claim. *Batten down the hatch with the proper investment in software and technology upgrades.*

- **There's no magic right answer or right code**. Payers may follow the Centers for Medicare and Medicaid Services (CMS) closely but not completely. Since payers are not bound to adopt a universal set of edits, each may have their own unique edits and authorizations that may not map with those of your organization. With the vast number of codes at play, *be prepared for a greater chance for variances*.
- **CMS will not penalize, hold a claim or authorize audits for the next 12 months as long as your coding is in the correct family.** According to CMS guidelines, "For 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family."[1] *Remember, this is not a blanket of freedom—you still need to get the code right so that you don't delay or lose reimbursement in the future. Specificity required for medical necessity or authorizations as well as in National or Local Coverage Determinations will still need to be met.*
- **There will be difficulty calculating PQRS quality scores but penalties will be suspended for twelve months.** According to CMS, "For all quality reporting completed for program year 2015 Medicare, clinical quality data review contractors will not subject physicians or other Eligible Providers (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM) or Meaningful Use (MU) penalty during primary source verification or auditing relating to the additional specificity of the ICD-10 diagnosis code, as long as the physician EP code used a code from the correct family of codes."[2]

Be Vigilant Post ICD-10

As most professionals understand, ICD-10 requires a different structure and logic to comprehend and implement. Intuitively we all understand what needs to be done; however, people can quickly fall back into old patterns once they return from training and are taking care of patients. Keeping watch over the ICD-10 transition will be an important part to achieving compliance. For the most part, experienced healthcare professionals will know that some risks are imminent. The key is to keep watch and be ready to identify the early warning signs that may lie ahead.

Three Common Warning Signs

1. Your organization has a large back log of bills or bill holds because they are stuck in the queue awaiting proper coding, increased specificity or require other edits.
2. Provider productivity levels have decreased.
3. "Discharged not final billed" levels are increasing.

What You Already Know Is Still Important

Fortunately, there are several facts regarding the imminent impacts of ICD-10 that you can expect. For instance, we know that everyone covered by the Health Insurance Portability and Accountability Act

(HIPAA) is affected by ICD-10 including providers and payers who do not deal with Medicare claims. And for better or worse, we know that we will have the same compliance risks after October 1 that we had before September 30th. It won't change that much, it will just be wearing a new set of codes and the climb to compliance will be steeper.

Mitigating the risks and minimizing disruption to your claims and reimbursement process will most likely require more time for providers to adequately document care provided and coders and billers are going to need more time for verifying and processing.

Success in making the transition will likely be in direct proportion to the amount of "connectivity" you have embedded in your organization. It will require improved technological connectivity and interfacing between your electronic medical records and claims editing systems. It will require increased human connectivity between coders and providers and providers and patients, none of which will achieve much if you haven't already established the underlying clinical documentation excellence needed to avoid errors from code ambiguity and outdated terminology usage.

Conclusion:

Only history will tell how quickly and adeptly our industry adapts to and complies with the massive changes ICD-10 presents. It may well turn out to be our industry's Y2-K. But one thing is certain; the tools that you will use to "crack the code" will benefit your organization and the populations you manage in the long-term. In our quest to get it right, the greater connectivity and specificity it will require may very well lead us into a world where we will welcome improved outcomes, reduced compliance issues, and appropriate reimbursements as "the new normal."

About the Author

Wayne is a part of the DHG Healthcare CFO Advisory team with over 23 years of experience in healthcare. He has focused on financial improvement and clinical documentation improvement initiatives, fraudulent claims defenses and self-disclosures, identifying and quantifying impacts of billing edits and denials and assisting with managing broader operational improvement projects. He currently leads the firm's ICD-10 readiness assistance activities a well a many compliance related matters including the firm's role as Independent Review Organization for facilities serving under Corporate Integrity Agreements. He has served large health systems, academic medical centers, regional hospitals, physician practices, post-acute care settings, home infusion and DME providers throughout the course of this career. Wayne is a certified public accountant in the state of Georgia.

End Notes

[1] CMS FAQ https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf

[2] CMS FAQ https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf