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Prepare for the ICD-10 Transition

By GRETA WEIDERMAN

If you haven't prepared your staff for next year's roll out of the new ICD-10 medical coding system, now is the time.

Even if your staff is ready to use the new system, its implementation may still result in delayed payment of claims.

"When ICD-10 goes into effect, (physicians and hospital groups) need to have a line of credit that would cover their expenses for three to six months, because they may not be paid," said Shelly Bangert, director of revenue cycle management at Hawthorn Physician Services Corp. in St. Louis.


Shelly Bangert

It's no surprise that doctors are leery of the financial impact of the change.

A survey by the American Health Information Management Association and the eHealth Initiatives found that 38 percent of providers think revenue will decrease in the year following the move to ICD-10, 14 percent believe the change will be revenue neutral, and 6 percent think the change will increase revenue, according to a statement by Edifecs, a global health information company that sponsored the survey.

Multiple delays in the ICD-10 compliance date have been a relief to unprepared providers, but an annoyance to those ready for the change. "Some (providers) had already done their training and may have to do some refresher courses," said Laura Palmer, senior industry analyst at the Medical Group Association, an association for medical practice administrators and executives.


Laura Palmer

The Centers for Medicare & Medicaid Services has twice delayed implementing the system. It was first scheduled to take effect in 2013, then in 2014 and now on Oct. 1, 2015.

ICD-9 is 30 years old, and its structure limits the number of new codes that can be created. Diagnosis coding under ICD-10 (for clinical use) has three to seven digits, while ICD-9 had three to five digits.

The switch will require physicians to bill for more specific diagnoses, and their staffs are learning how to document patient care so claims are not automatically denied. Coders will have to examine the clinical documentation more closely, which will take more time and manual labor since there will be many more codes to investigate, according to Palmer.

ICD-10 is more than doubling the claims codes to 70,000, according to Bangert. Hawthorn, which has contracts with about 200 physicians, is ready for the switch, but Bangert cautions that ICD-10 will likely make denial claims management more complicated.

Now more than ever, insurance companies have sophisticated, automated processes that deny a claim if it is not submitted correctly.

"Payers – their philosophy is, 'when in doubt, don't pay it,'" Bangert said.

About 90 percent of claim denials can be prevented if billers collect updated information on patients and "scrub" the claims (or make sure they are coded correctly) before submitting them.

Each denied claim costs a physician or medical group $25 to $30 in man hours, and 10 to 20 percent of medical claims overall are denied, Bangert said.

Who needs to transition?

Health care providers, payers, clearinghouses and billing services should prepare to comply with ICD-10. The system affects diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

Claims with ICD-9 codes for services provided on or after the compliance deadline (Oct. 1, 2015) cannot be paid.

Source:Centers for Medicare and Medicaid Services

- Have a software system in place that works with the new code set.
- Provide coders with specialty training, and test the system.
- Make strides to improve relationships and communications with payers.
- Proactively find out what major payers in your region will cover for common vaccines or procedures.

Source: Laura Palmer, senior industry analyst at the Medical Group Association

Testing your system

The Centers for Medicare and Medicaid Services (CMS) adopted a four-step approach to help physicians prepare for the switch to ICD-10:

CMS internal testing of its claims processing systems.

Provider-initiated beta testing tools: CMS is providing three links for providers to test their systems to determine if they will work with ICD-10.

Acknowledgment testing: This gives submitters access to real-time help desk support and allows CMS to analyze testing data.

End-to-end testing: Next year, CMS will offer three separate end-to-end testing opportunities, which allow providers to test claims to Medicare with ICD-10 codes.

Source: Centers for Medicare and Medicaid Services