ICD-10-CM: Impact on Physicians' Fears, and What Comes Next [sponsored article]

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This article is published in sponsorship with Berkeley Research Group (BRG).

Uncertainty and fear permeated physicians' offices leading up to October 1, 2015. The transition to ICD-10-CM was reminiscent of the Y2K scare. A new coding set would replace the existing ICD-9-CM classification system with thousands of new diagnosis codes, additional material in the coding manuals, and—most important—coding system changes from a mainly numerical system to an alphanumeric structure of up to seven characters in length.

The transition to ICD-10-CM left many healthcare providers feeling apprehensive over how the process would affect their practices and revenue stream. In an attempt to mitigate risks and prepare their offices, many provider practices took a proactive approach by investing in new or updated computer software, training for staff, and updated documentation templates.

To further prepare for the transition, providers had to understand that change would occur not in their focus on patient conditions, but rather in the selection and appearance of the new set of diagnosis codes. Although ICD-10-CM would increase diagnosis codes by the thousands, each additional code would not pertain to every practice. Thus, specialties could concentrate their efforts on the limited changes that directly impacted their practices.

As the first anniversary of ICD-10-CM go-live approaches, much uncertainty remains. Information on the overall impact of ICD-10-CM is scarce without CMS, insurers, or data-mining entities performing audits or data analysis. CMS guidance states that for twelve months following ICD-10-CM implementation, Medicare would process medical claims without auditing valid ICD-10-CM codes as long as the code billed belonged to the correct family of codes. A family of codes has been defined as the same ICD-10-CM three-character category from which the full code stems. Codes within a category are clinically related but have additional information regarding the specific type of a condition. For example, Crohn's disease, which has the three-character category K50, can be further defined: Crohn's disease of small intestine without complications as K50.00; Crohn's disease of small intestine with intestinal obstruction as K50.012; and Crohn's disease, unspecified, without complications as K50.90.

Guidance applies to Medicare review contractors, which include Medicare Administrative Contractors (MAC), the Recovery Auditors (RAC), the Zone Program Integrity Contractors (ZPICs), and the Supplemental Medicare Review Contractor. However, the guidance does not change the coding specificity required by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The coding guidance described in an NCD and/or LCD contains specific diagnosis codes that must be used when billing for certain services. There is no payment review leniency for ICD-10-CM codes from commercial payers. Each commercial payer must determine payment and audits due to the change to ICD-10-CM.

Keeping in mind that many physicians and other healthcare practitioners belong to small practices, CMS allowed some flexibility in ICD-10-CM coding for Medicare fee-for-service audit and quality programs. This flexibility provided smaller practices additional time to gain experience throughout the transition. Diagnosis coding had not been a major element in reimbursement for Part B physician billing because the claims are billed and paid using CPT codes. This is in contrast to facility billing, where billing and reimbursements are based on the ICD-10-CM codes.

Practices should proceed with caution, despite the announced delay in external auditing. A truly successful transition will depend on strong internal controls driven by self-auditing. A proactive approach to auditing and monitoring work, documentation templates, and superbills will help practices reduce the likelihood of issues in productivity, reimbursement, claims submissions, and processes in the long run. Preemptive assessments will help practices anticipate issues and identify opportunities for improvement.

CMS has offered providers an assessment and maintenance toolkit to assess ICD-10-CM progress based on key performance indicators. The assessment is designed to identify potential issues that affect productivity or cash flow. A practice should establish a baseline first and then monitor. Potential key performance indicators are:

- Days to final bill
- Days to payment
- Claims acceptance/rejection rates
- Claims denial rate
- Payment amounts
- Coder productivity
- Requests for additional information
- Daily charges/claims
- Clearinghouse edits
- Payer edits
- Incomplete or missing charges
- Incomplete or missing diagnosis codes
- Use of unspecified codes
- Medical necessity pass rate

Additional tips for a practice include:

- Develop a feedback system to share thoughts and suggestions from members of the staff to streamline communication from each practice area
- Track issues as they arise, develop a corrective action plan, and follow resolution
- Track and provide education from coder queries
- Audit clinical documentation and provide education from the reviews
- Share official educational materials to clinicians and coders to keep staff current on coding
- Review unspecified diagnosis coding
- Review system issues and upgrades

The transition to ICD-10-CM has seemed to be a non-issue. Some may credit this to the large investments practices have committed in preparation. Others may argue that the lack of external auditing has resulted in a false sense of security. Regardless, internal auditing and monitoring is a critical component to future success, and until CMS begins auditing, the overall impact has yet to be determined. Practices must remain vigilant in self-monitoring. External audits will occur, and the findings could result in unexpected negative impacts to cash-flow and workflow processes.

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Original source:
Zarick, Deborah; Abda, Renee. "ICD-10-CM: Impact on Physicians' Fears, and What Comes Next [sponsored article]" (Journal of AHIMA website), September 16, 2016.

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