Preparing for ICD-10

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On Oct. 1, 2014, ICD-9, the outdated code sets used for 30 years to report medical diagnoses, will be replaced by ICD-10. Not only is the structure of ICD-10 entirely different from ICD-9, the number of codes increases from approximately 13,000 to 70,000. The level of specificity presented with such an increase in codes is daunting for both the coder, who must select the code, and for the radiologist, who must provide the necessary details to support that selection.

To transition successfully to ICD-10, the coder and radiologist will need to work in tandem to meet dictation requirements, while the billing entity updates and tests all computer systems to accommodate claim submissions with ICD-10. The radiologists at Sand Lake Imaging (SLI) and the billing and coding staff at Physician's Support Systems (PSS) have already commenced our preparation for ICD-10 implementation using a productive and collaborative team approach.

The billing preparation began well over a year ago with the necessary changes to the coding and billing software. Simultaneously, coders began the educational process by utilizing resources from such organizations as the American Academy of Professional Coders (AAPC), the Centers for Medicare and Medicaid Services (CMS), and a multitude of training tools offered by private insurers. Radiologists, in the meantime, began participating in webinar sessions focused on properly documenting the clinical information supporting the final coding of the report. Specific nomenclature and attention to increased descriptive and diagnostic terminology have been stressed in these sessions. As the coders achieve a level of confidence in understanding ICD-10, they have facilitated this collaborative process with the radiologists by using a dual coding approach. This system permits coders to code a dictation in ICD-9, and then, if possible, in ICD-10. Those dictations that meet the requirements for ICD-10 are shared with the radiologists and help underscore the importance of dictating at that level. If the dictation does not meet ICD-10 requirements, the coder conversely identifies any deficiencies and offers constructive recommendations. By closely continuing to work with one another during the 9 months leading up to October 1, 2014, we are confident that the dictations generated at that time will be structured to fully support ICD-10 coding.

Impact on cash flow

Of course, the magnitude of this change and the level of specificity required will, undoubtedly,

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impact productivity and cash flow. Utilizing dual coding allows the coder to become proficient and productive coding with ICD-10. With the consistent feedback to the radiologists, they, in turn, become adept at dictating to the level required by ICD-10. Time on task allows both the coder and the radiologist to become familiar with the new coding methodology and, thereby, minimize production problems. Another benefit to this collaborative approach is the reduction in returned dictations to the radiologist due to inadequate ICD-10 documentation resulting in time-consuming re-work and disruption to workflow.

By following the approach outlined, coders, radiologists, and billing staff train and become knowledgeable with ICD-10. But the unanswerable question is whether Medicare, Medicaid, and private insurers will be ready for our ICD-10 coded claims! During the claims submission transition from 4010 to 5010 (in preparation for ICD-10), many providers across the nation experienced significant payment delays because the payers and clearinghouses, despite extensive testing, were woefully unprepared. While the clearinghouses and the payers engaged in finger pointing, providers watched their payments dwindle. Fixes to the problems often took up to a month to rectify. Will these problems repeat with ICD-10? Adding to the uncertainty regarding implementation of the new coding system is Medicare's reluctance to offer extensive end-to-end testing for ICD-10. In light of the problems with the rollout of HealthCare.gov, Medicare seems more willing to engage in greater testing, but that testing is not scheduled to begin until March 2014. Yet of even greater concern, in the aforementioned problems with the 4010 transition to 5010, more problems with private insurance companies were encountered compared to Medicare. It is important to keep in mind that private practices often have payer mixes higher in private insurance as compared to Medicare, which will render them at increased risk for cash flow problems if the payers are not ready. Having extra reserves of cash for operating expenses is highly advised.

Monitor warning signs

Just as it is critical for the coders to work closely with the radiologists to accurately prepare a dictation with the correct ICD-10 code for claim submission, the billing staff must be prepared to closely monitor all claims submissions beginning on October 1, 2014, and report and quantify any problems to the radiologists. Claim file acceptance should be monitored closely, with special attention paid to rejection codes. One of the first indicators of trouble is the sudden appearance of an error code, usually hundreds of them that have not been seen before. Electronic claim submission has always been our ally for early problem detection. Immediate action can be initiated with the payer and/or clearinghouse. If the worst-case scenario occurs and a payer is unable to accept any claims with ICD-10, requesting instead that ICD-9 be utilized, the dual-coding system becomes invaluable and allows for a rapid response to a payer's request.

Monitoring the accuracy of a practice's contracted payments has always been critical, but with the implementation of ICD-10, this becomes paramount. Most components of an insurance company's software are impacted by ICD-10. Software changes could unintentionally alter a practice's payments. Our billing processes are already established via automation to insure that payments posted to a patient's account comply with that patient's insurance's contracted amount. We strongly recommend that such an automated system be put into place prior to ICD-10 implementation to facilitate rapid resolution of any discrepant payments.

In conclusion, preparing for ICD-10 requires educational collaboration between coders and radiologists, testing with payers, intense monitoring of claims submissions with quick problem identification, and review of contracted payments. With all of this rigorous preparation, we are prepared for a smooth transition to one of the most significant changes to coding and reimbursement in our healthcare system in the last 30 years.