Dotting the 'I' in ICD-10

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Caroline Rader Znaniec
Principal Owner of Luna Healthcare Advisors LLC
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Plenty of time has been given to the healthcare provider community to prepare for the implementation of ICD-10. Many providers are anxious to get started, insist they are prepared and tired of hearing about how to prepare. But have you dotted your "I" in ICD-10? You may be surprised what opportunities may still linger.

Registration

There are many ways in which a patient can enter your facility. Each entry point provides an opportunity for breakdown in the revenue cycle process specific to identifying the medical necessity and diagnosis requirements for clean claim submission. The initial diagnosis code obtained may be a provider's only ability to qualify an item, service or procedure for payment. Providers who have not identified the various entry points and workflow processes, risk much re-work in the business office; if not an increase in overall denials. Your registration staff is your front line to maintaining your revenue stream. Empowered with the appropriate education they can be a valuable (if not the most valuable) asset to maintaining overall revenue integrity in October.

Consider this scenario – A patient presents at the diagnostic center for an extremity plain film x-ray following a fall days prior. The requisition is completed by the patient's primary care physician. The requisition provides for a diagnosis of "pain in limb", which under ICD-9 may have sufficed under most plans for medical necessity. However, under ICD-10 the diagnosis requires further specification to understand the location of the condition (e.g. left arm), whether to exam is related to initial or subsequent encounter and if the condition is acute or chronic. The registration clerk searches to translate the narrative diagnosis and without having the additional elements, the clerk selects a single unspecified code. The

results of the test are inconclusive. The claim is processed with the unspecified diagnosis code and without the additional detail to describe the condition and episode of care. The test is denied for lack of medical necessity. Had the clerk been educated on the change from ICD-9 to ICD-10 for this common test's diagnosis requirements, the clerk could have called the ordering physician to clarify or looked to other options including presentation of a financial waiver.

Community Physicians

In many hospitals, orders for services are primarily sourced from community physicians. Lack of outreach efforts for the community physician population will likely hit the hospital's bottom line. The opportunity to collaborate with the community physician population is two-fold. First, including the community physicians in education efforts can provide for consistency in physician training, communicate the expectations of the hospital, and ultimately reduce DNFB and denials. Secondly, proactively working with the community physicians can open the lines of communication between the hospital and physician office. Taking a united approach can place the physicians at ease knowing they have a lifeline. It's a win-win scenario. For your top referral producing groups, know who and how to contact at the physician office to clarify orders and provide regular feedback. Identifying and correcting issues at the front end of the revenue cycle will aid in maintaining your overall revenue integrity.

Outpatient Non-Physician Services

Most of the emphasis around ICD-10 has been targeted to inpatient services and physicians. Providers that have not effectively educated their outpatient non-physician service staff risk decreased revenues and increased resource needs and costs towards working those accounts discharged not final billed (DNFB), denied or returned to the provider post-billing. Those services most affected include rehabilitative services, medical nutritional therapy, diabetes self-management training, partial hospitalization and intensive outpatient therapy, and infusion therapy. In all of these services, non-physician staff are responsible for assessing the patient, completing plans of care and treatment plans for physician certification. The physician is most likely to concur and sign off on the certification, and not provide coding feedback for the hospital to receive optimal reimbursement. With ICD-10 the level of specificity increases (e.g. distinguishing bone from joint), the episode of care may require definition (e.g. injury location and context), if the service is related to a complication or condition resulting from injury, diagnoses involving multiple sites may require multiple ICD-10 codes, and establishing acute from chronic conditions.

Payer Relations

The payer's hold just as large a stake in a provider's success under ICD-10 as does the provider organization itself. The payer's ability to process claims efficiently and effectively is measured daily. Profit margins for the payer and provider both decrease the more times a claim is touched. Payers want you to succeed and obtain the revenues to which you are entitled. And to assist providers, all payers have assigned account representatives. They are your resource in understanding coverage and reimbursement policies, but even more so in

understanding your provider organization's unique woes. If you have not already done so, schedule regular standing meetings with your major payers; including but not limited to, Medicare and Medicaid. Have a set agenda in place to discuss trends in claim processing issues, track issues, detail the steps to be taken to resolve and hold those involved accountable with expected timelines. Keep copious notes and distribute them to the payer representative.

Revenue Cycle Metrics

Prior to implementing ICD-10, a provider should understand their current benchmarks for key revenue cycle indicators. While published benchmarks may be helpful, they may not provide for realistic performance expectations post ICD-10 implementation. If you are not using or measuring yourself against those benchmarks today, why would you expect to meet them in October or beyond? Example key indicators to monitor in a post ICD-10 world include the following:

Clinical Documentation Improvement

- Query Volume and Response Rates (concurrent and retrospective)
- Query Response Type
- Query Aged Backlog
- Case Mix Index (CMI)
- DRG Swing

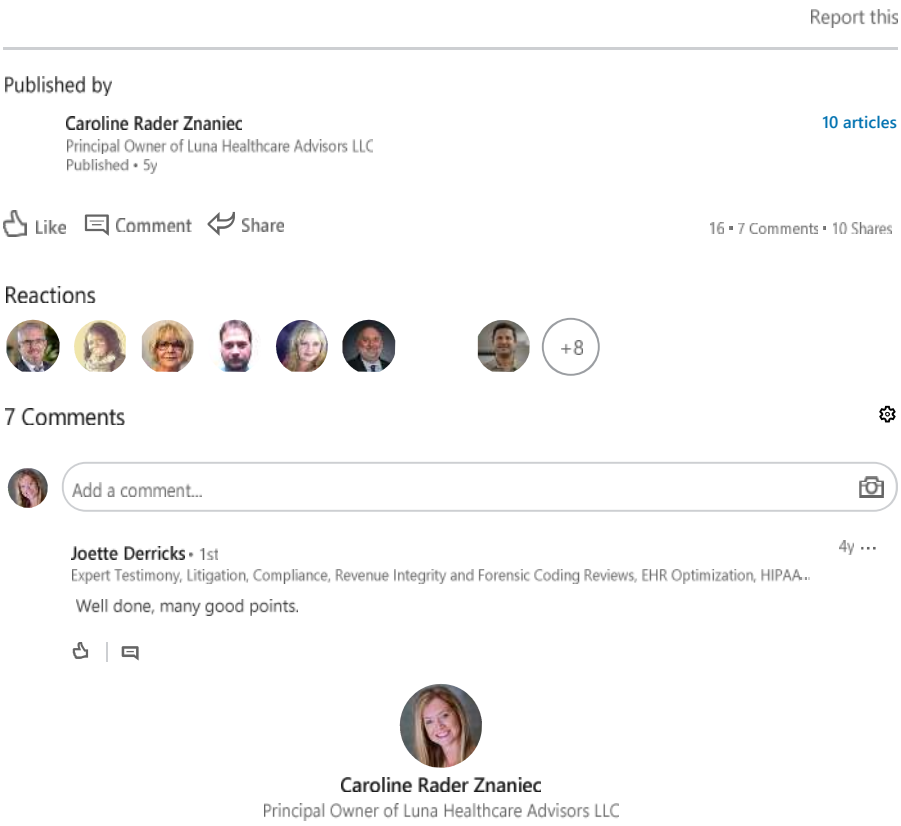
Coding

- Accuracy
- Productivity
- Discharged Not Final Billed (DNFB)

Business Office

- Accounts Receivable, by payer
- First Pass Resolve Rate
- Denials by Payer, by type (e.g. coding, prior authorization)
- Volume of Accounts in Pending Status
- Expected Revenue by Payer vs. Actual Revenue by Payer

Luna Healthcare Advisors LLC is a specialized consulting group with a focus on healthcare provider integrity consulting. Our core services address healthcare documentation, coding and billing compliance. Additional services expand into other compliance hot areas including privacy and security, transaction due diligence, and compliance program effectiveness, as well as related operational processes including electronic medical record (EMR) assessment, design, interface testing and implementation assistance.



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