

HOW TO MAKE ICD-10 WORTH THE TROUBLE

Proper coding and practice economics in the modern era.

BY CYNTHIA MATTOX, MD



The October 2015 implementation date for the 10th revision of the International Classification of Diseases (ICD-10) came and went in most eye care practices without major glitches. Ophthalmologists in general were well prepared by their national organizations and through the commitment of the various electronic health record companies to provide the

resources and training doctors needed.

How can you put the coding system to best use in your practice and even squeak out some added value from the time you have spent preparing for ICD-10?

ACCURACY IN CODING

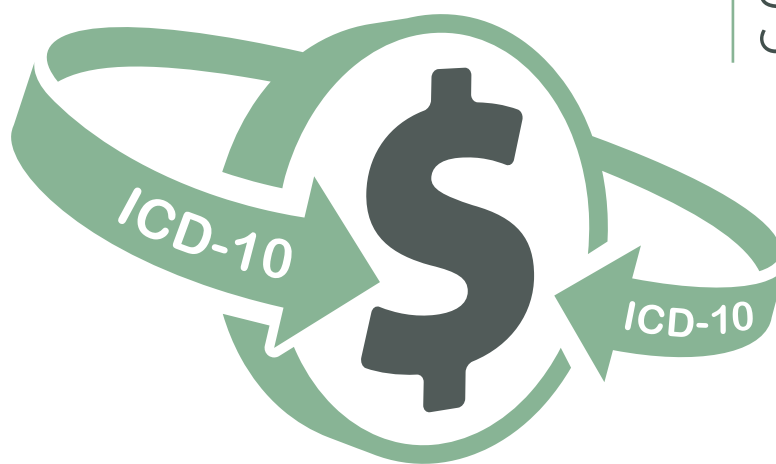
As the saying goes, you reap what you sow. By being meticulous in coding every service, many of your practice's billing processes will be streamlined and more efficient. With every lapse in coding, your staff will have to revisit the claim, try to understand your chart notes, and most likely involve you again in the conversation of how to code a service that occurred days ago.

Even if you use "claim scrubber" software before your claims go out, learning and understanding different payer coding rules will enhance the billing process. By coding accurately according to known payer rules for tests and procedures, you will prevent rejections, thus saving your staff time and work. Every rejection requires at least double the work of an initial claim. The former entails research, revision (if possible), the placement of an appeal within a tight deadline, and then follow-up on the results.

ICD-10 increases complexity. For example, you now often code for laterality and stage of glaucomatous damage. Codes that you and your staff knew by heart in ICD-9 are no longer recognizable in ICD-10. All of this slows down the coding and billing process, and you have to make up for that somehow in the near term. Being accurate and coding every service are key.

OPPORTUNITIES TO SPOT MISSING REVENUE

Added granularity in ICD-10 can serve to double-check coding accuracy. For codes that have laterality, linking the ICD-10 code with laterality to the right/left/eyelid modifiers on the tests and procedures that require laterality can help ensure that all claims are being sent out appropriately. Did every IOL



power calculation get billed for every cataract surgery? Run a report to check that the ICD-10 code for cataract with laterality lines up with the associated code for A-scan 75219-left/right or optical coherence tomography scanning 92136-left/right and that the cataract surgery right/left after the surgery is performed. Doing so could identify missing revenue.

PRACTICE PROFILING

Nearly all private payers know how you code and bill. They are profiling your practice. If you are a subspecialist, you most certainly "cost" more than a comprehensive ophthalmologist or optometrist due to your higher resource utilization for complex cases. This fact may have already put a target on your practice; a higher copayment may be required for patients in certain plans to see you, or they may not be able to see you at all.

In the Medicare program, 2015 claims data will be used to assign you to a tier based on your resource costs. Depending on how the rules are structured (the Centers for Medicare & Medicaid Services has still not revealed its plan), your practice may incur a penalty from the value-based modifier. In the past, based on claims data alone, the payers could not tell if the population you care for has more severe glaucoma than patients at the practice down the street. With the new glaucoma staging digit required on the most common types of glaucoma, you are able to document the severity of your patients' disease state more accurately within claims data. No, the system is not perfect, and it does not tell the whole story for each patient.



AT A GLANCE

- Every rejection requires at least double the work of an initial claim. It is essential to be accurate and code every service.
- By using ICD-10 to double-check coding accuracy, you may identify missing revenue.
- With the new glaucoma staging digit, you are able to document the severity of your patients' disease state more accurately within claims data.
- A taxonomy code in the works could also help distinguish glaucoma subspecialists and assist with practice profiling by private payers.

For a population of patients, however, the stratification will prove useful. This is what drove the American Academy of Ophthalmology and the American Glaucoma Society to develop the staging code system for use in ICD-10. Glaucoma subspecialists spend more on resources (testing and surgery) than doctors who do not care for patients with severe glaucoma. Now, glaucoma subspecialists can explain their resource use via claims data that are easily accessible to payers. In addition, it paves the way for accurate peer group comparisons of doctors who have similar practice profiles.

THE FUTURE

A new possible avenue for distinguishing subspecialists is a taxonomy code. It would be placed on your claims, much as you currently have a designation as an ophthalmologist. A glaucoma, retina, or pediatric specialist designation could also be used to help with profiling and peer comparison in private payer programs, the value-based modifier, and on into the new Merit-Based Incentive Payment System scheduled for 2019. The application for the taxonomy designation for glaucoma is wending its way through the process now and should be available in late 2016.

The American Academy of Ophthalmology's IRIS Registry can help with the analysis of disease severity, outcomes, and resource use via coding as well as actual data extracted from charts. It should enhance ophthalmologists' care of patients. Coding within the IRIS Registry is already used for various quality measures. It can become even more specific and helpful with some of the new ICD-10 families of codes.

CONCLUSION

Coding is a necessary chore. Accurate and efficient execution will help many internal and external processes that affect your payments. ■

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