

ICD-10-CM Readiness: Preparing for the Great Unknown

BY RIVA LEE ASBELL

The Centers for Medicare and Medicaid Services have postponed the deadline for implementation of ICD-10-CM from October 1, 2014, to October 1, 2015, thereby giving practices some breathing room and an opportunity to get prepared for the change. Whether or not changes are implemented by the 2015 deadline, the delay presents an opportunity for practices to perform an assessment of their coding and compliance. As innumerable reimbursement consultants have noted, the main problem with preparing for ICD-10-CM is the lack of proper guidance for chart documentation and the repercussions that practices will experience due to audits, claim rejections, and resulting decreased productivity.

ICD-10-CM differs from ICD-9-CM in that more clinical knowledge is often required in order to properly select diagnoses and prepare billing claims. Success will be achieved only if there is a collaborative effort by all staff members—most of all, by the physicians.

CHARACTERISTICS OF ICD-10-CM

ICD-10-CM has many similarities to ICD-9-CM. Both sets of diagnosis listings are formatted with an alphabetical index and tabular list that is divided into sections, such as the anatomic ones or external causes. Codes may be found in sections different from where one is used to searching. There has been a lot of hype regarding the number of codes in ICD-10-CM, but practices never used all 14 000 codes in ICD-9-CM and will not be using all 69 000 in ICD-10-CM. Within ophthalmology, retina practices will be using fewer codes than many other ophthalmic subspecialties.

Laterality and Specificity

Two key words pertaining to ICD-10-CM are “laterality” and “specificity.”

Laterality simply refers to the location that applies to the diagnosis. In retina practice, this is the right eye, the

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left eye, or both eyes. Each specific diagnosis will have a different code depending on which eye is affected. Also, there are codes for when the chart documentation does not specify location.

ICD-10-CM codes are specific for the location; therefore, there are different codes for the same problem depending on whether the condition is present in the right eye, the left eye, or both eyes, or if laterality is not specified in the chart documentation. This change contributed to the significant increase in the number of codes in the new system.

Specificity refers to the granularity of each diagnosis. A clinical background is necessary for properly coding specificity, so physician direction and input are required. This was often unnecessary when using ICD-9-CM. There are different areas that specificity can apply to other than location (an example can be found in Table 1). It is extremely important that the disease entity itself and the specific characteristics being treated are coded to the most granular level possible. Code listings are themselves very granular. If the complete diagnosis is not listed in the final impression in the chart documentation, then it will be difficult, if not impossible, for billing personnel to determine the diagnosis. Without a complete diagnosis listed in the chart documentation to support the level

TABLE 1. EXAMPLE OF DIFFERENT DIAGNOSIS CODES IN ICD-9-CM AND ICD-10-CM

Diagnosis Code Description	ICD-9-CM	ICD-10-CM
Exudative retinopathy (Coats disease)	362.12 Exudative retinopathy	H35.021 Exudative retinopathy, right eye

billed, offices will find it difficult to successfully defend an audit recoupment request.

The most daunting aspect of specificity is the emphasis in ICD-10-CM coding on listing every possible cause for a given diagnosis. For example, ICD-10-CM adds to the code a letter (A, D, or S) indicating that the office encounter is an initial encounter (A; this is also the designation for subsequent visits during the time when the patient is actively being treated for the original encounter), a subsequent encounter (D; this is also used when the encounter being coded does not refer to a repeat injury of the same problem), or an encounter for complications or sequelae (S).

For example, for a patient who sustained an injury in which a small foreign body penetrated the globe and then rested on the retina, the ICD-10-CM code for the office visit would be S05.51xA (penetrating wound with foreign body right eye). The “A” in this code indicates the initial encounter for that specific diagnosis, which is needed because it was a traumatic injury; because an encounter code must always be listed as the 7th digit, an “X” is used in the 6th digit. If the patient’s visit were a subsequent injury (not a repeat injury of the same problem), then a “D” would be used in the 7th position; for sequelae or complications of the original injury or late effects, an “S” would be used.

ICD-10-CM may require other sets of codes to designate the circumstances in which the trauma took place. For example, code X71.9 (drowning in bathtub) details where or how the patient drowned. These codes are not required nationally by Medicare.

CHART DOCUMENTATION

The most important physician responsibility is to make sure that every chart has specific and thorough chart documentation so that an auditor would be able to easily select the proper diagnosis. The most important diagnosis, in the physician’s estimation, should be listed first. This is easily accomplished by those using paper charts; however, physicians using electronic health records (EHRs) should personally do this and not rely on the system. A physician should not depend on an EHR-generated diagnosis code until he or she is sure of the insurer’s requirements and the system’s ability and accuracy in accomplishing this task. Tips for completing encounter forms, which are checklists used during billing

TABLE 2. ENCOUNTER FORMS

Encounter forms are used as checklists during bill generation. Those who use EMRs, and therefore electronic encounter forms, should consider using paper forms in the early stages of ICD-10-CM transition to make sure the forms are filled out correctly, and then gradually transition back to electronic forms.

Here are some tips to follow:

- Perform an analysis of your current most frequently used diagnosis codes—by physician and/or practice, as applicable—and use the results of that analysis to develop a quick reference of essential ICD-10-CM codes to be used on the encounter form.
- If you are in a practice with nonretina specialists, consider developing your own encounter form. It probably will be more concise than that of a comprehensive ophthalmologist, for example.
- A digit in each code is reserved for laterality. In the ICD-10-CM chapter on eye coding, 1 = left eye; 2 = right eye; 3 = both eyes; 9 = information not specified in the chart documentation. Instead of listing each code individually (the right eye, the left eye, both eyes, or unspecified), put the digits 1, 2, 3, and 9 in a box on the encounter sheet where the physician selecting the code has only to then select which digit applies to the encounter. Because only the core diagnosis code must be listed on the encounter form, 3 codes for each diagnosis are thereby eliminated from the list.

by physicians using paper or electronic records, are found in Table 2.

External audits of a practice’s existing chart documentation may highlight which areas need attention and which are susceptible to punitive audit repercussions.

FINANCIAL IMPACT

The ultimate goal for both the practice and the insurer is the smooth processing of claims. The practice’s goal should be the efficient preparation of claims for immediate processing by the insurer. The problem is that the insurer’s requirements for specificity are often unknown.

A Google search of “ICD-10-CM loss of productivity” yields pages of studies that forecast a significant decrease in productivity when ICD-10-CM is implemented: Billing personnel will not be able to process as many charts or rebillings as they could before ICD-10-CM was implemented, and claims rejections (and frustration levels) are bound to increase.

Practices should consider adding full-time or part-time help in the billing department for ICD-10-CM implementation. What happens if a billing person leaves or becomes ill? It is critical to have someone else available as a contingency plan.

There are bound to be glitches in insurers’ claims processing. ICD-10-CM readiness includes being financially prepared to sustain lack of timely reimbursement, and physicians should prepare a nest egg and arrange for sufficient credit to be able to absorb the initial financial shock of ICD-10-CM transition.

PERSONNEL AND TRAINING

Physicians, Office Coordinators, and the Billing Department

Physicians must take a proactive leadership role in the transition from ICD-9-CM to ICD-10-CM. Physicians are the scaffolding of this transition, and their responsibilities range from assuring that chart documentation is complete and correct to creating an atmosphere of openness, participation, and help. These duties cannot be completely delegated to ancillary personnel.

Physicians should consider having their most knowledgeable and interested technician act as a liaison between the physicians and the billing department. Doing so may foster good working relationships and facilitate efficient billing. This person, or the administrator or office manager, would also be a good candidate to fill the position of coordinator, someone who would implement the entire ICD-10-CM readiness program.

A practice management system for dealing with day-to-day activities once implementation begins should be set up in retina practices. Also, the following implementations should be considered:

- Instructions for billers and coders to save difficult cases until the end of the day, at which time additional help may be available, and,
- Biweekly (or whatever time frame is necessary) meetings during the early transition, during which designated physician(s) review cases and provide assistance.

Training

Physicians should start now; the implementation date is right around the corner. Investing in proper training for all physicians, billing personnel, and other key staff

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members is important. The best instructional courses to help make offices ready for the implementation of ICD-10-CM are those that are specific to ophthalmology. National ophthalmic societies sponsor such courses, and some consulting firms offer in-house training. Large practices need to be sure that all physicians in the practice are trained. Hospital courses are too general and will not give as much ophthalmology-specific information as the aforementioned courses. Ancillary personnel should also take these courses: If more people in an office are familiar with the transition, it will go smoother.

Buying the 2014 ICD-10-CM book and the 2014 ICD-10-CM Mappings books is a good start. Patterns and logic behind the system will become less opaque after engaging these texts.

A PERSONAL NOTE

This is going to be a challenging project for all—practices, insurers, and even consultants. However, it may not be as horrific as it seems.

I personally believe that specificity may not be as big a problem as some courses have touted. Practices’ and insurers’ aims are aligned: Both groups want claims to be processed efficiently. Insurers surely do not want the same claims resubmitted, given the multiple telephone calls, work, and expenses associated with resubmission. Many insurers will pay on the primary diagnosis, which is why it is critical that practices pay special attention to their first diagnoses. Insurers’ computers match the submitted CPT code with the ICD-10-CM code, and if the claim information is a match the claim is processed. Insurers may become more stringent in requiring more diagnoses as time goes on, but I think they will be more lenient in the beginning. ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Florida. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.



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