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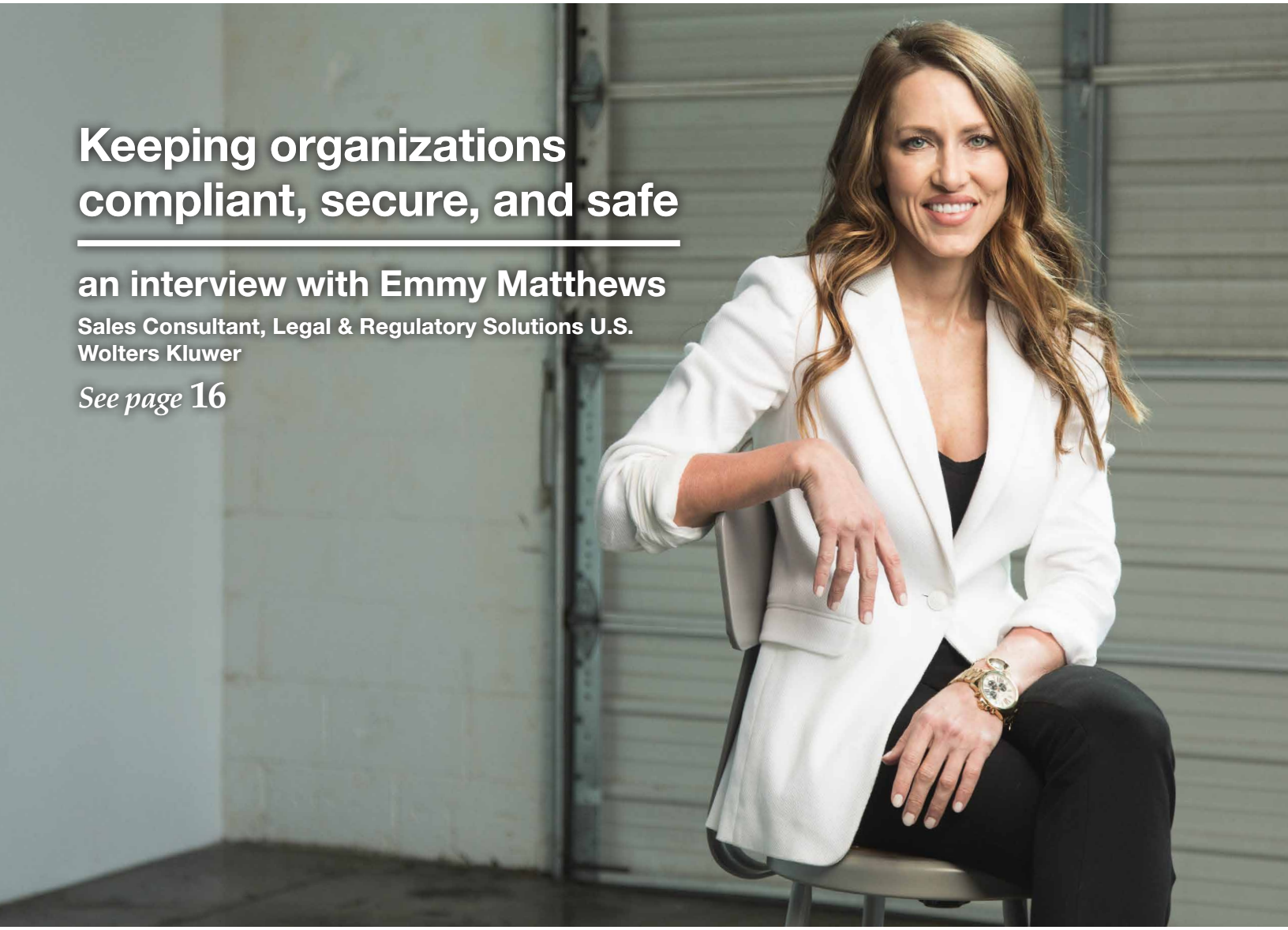

## Keeping organizations compliant, secure, and safe

### an interview with Emmy Matthews

**Sales Consultant, Legal & Regulatory Solutions U.S.**
**Wolters Kluwer**

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by Arlene Baril, MHA, RHIA, CHC

# ICD-10 transition: So far, so good… for now

» The ICD-10 transition has been smooth for providers and payers.
» CMS granted a 12-month denial grace period to physician providers if ICD-10-CM codes lack full digit specificity.
» Organizations should use extra time for a coding compliance assessment and provider training.
» Providers should pay particular attention to the accuracy of ICD-9-CM to ICD-10-CM crosswalk applications.
» New exclusion notes in some ICD-10 codes may also contribute to errors due to staff inexperience in the coding changes.

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Perhaps due to the multiple delays over the years, the healthcare industry's switch to the International Statistical Classification of Diseases, 10th revision (ICD-10) on October 1, 2015 has been surprisingly smooth, according to recent press coverage and analysis. In fact, of the 4.6 million Medicare claims processed each day from October 1–27: 2% were rejected because of incomplete or invalid information, .09% were rejected because of invalid ICD-10 codes, .11% were rejected because of invalid ICD-9-CM codes, and 10.1% of all Medicare claims were denied.

Baril

An oncology news and information website declared: "ICD-10 Blows Over Like Y2K."[1] An article from a health information technology (HIT) industry publication, which featured comments from payer and provider group representatives who attended the Medical Group Management Association annual October conference, indicated the transition from billing 14,000 to 68,000 diagnostic codes and from 4,000 to 87,000 procedure codes has resulted in relatively few errors or phone calls to payers for technical support. As a representative from Humana stated, "… almost everyone who's submitting claims is getting it right."[2]

In the weeks and months ahead, however, coding reviews and risk adjustment score trends may tell another story. Or perhaps during a provider-claim or risk adjustment data validation (RADV) audit, a payer will identify numerous overpayment or underpayment errors that weren't detected on the first claim submittal, requiring a significant revenue adjustment for either party. Before either of these scenarios occurs, providers and payers may want to consider conducting an ICD-10-CM compliance assessment to identify and correct any potential deficiencies. The following are five items to consider during your post-ICD-10-CM compliance assessment.

**1. Focus on coding specificity**

In July 2015, providers breathed a sigh of relief when CMS announced that for 12 months, its contractors will not deny or audit Part B claims based solely on the specificity of the ICD-10-CM code, as long as the physician used a valid code from the right family.[3] This extra time allows providers to perform an internal audit focusing on the "when, where, and why" of coding specificity issues and to identify solutions.

**2. Enhance provider and coder education**
This coding review should help organizations identify the "who" regarding ICD-10-CM non-compliance. Staff coders may need training and providers may require assistance with charting, so accurate and acceptable ICD-10 claims can be submitted. Although CMS has agreed not to deny claims based on lack of ICD-10 specificity, these types of charting or coding-error patterns need to be remedied, so providers will be in full compliance by the time the grace period has ended.

**3. Scrutinize your crosswalk**
During the ICD-10 transition, our firm assisted several provider organizations that had been using a crosswalk application integrated with their EHR system which was inaccurately translating ICD-9-CM codes to ICD-10-CM. For one health system, at least 40% of the conversions were incorrect, but may not have been rejected by CMS due to the denial grace period. This discovery required IT staff to deconstruct the crosswalk application to determine the cause of the mistranslations. If using a crosswalk application, provider organizations should begin determining the software's accuracy by cross-referencing generated codes against another crosswalk application or translation tool. There are several free conversion tools available on the Internet, including one from the American Association of Professional Coders[4]; another from the site, www.ICD10data.com; and the GEMS crosswalk from CMS, *http://go.cms.gov/1WtGZld*. It is important for providers to keep in mind that ICD-9-CM codes do not all translate to a 1:1 conversion in ICD-10-CM. Multiple codes may be required under ICD-10.

**4. Watch for new exclusion notes**
New to ICD-10-CM are two types of exclusion notes pertaining to codes that are permitted to be billed together and those that are not, where ICD-9-CM had only one exclusion note. The first exclusion note, Excludes1, indicates that a certain code cannot be used with any other code from a similar set. For example, an ICD-10-CM code for superficial bite of the right thumb, initial encounter—S60.371A cannot be billed with anything from categories S61.05 or S61.15, which pertain to other bite injuries to the thumb. Conversely, the second exclusion note, Excludes2, means that it is not similar to the assigned code, so the additional code is permissible. So, with the thumb bite code, anything from category S60.2, which pertains to contusions to the wrist and hand, can be billed together. There are numerous other codes with Excludes1 and Excludes2 notes which, when coders become accustomed to the distinction, should prevent many claims rejections in the future.

**5. Look ahead to risk adjustment data validation (RADV)**
Geared toward payer organizations, but also impacting providers, the Department of Health and Human Services is rolling out the first year of Affordable Care Act (ACA) RADV audits next year to determine risk scores for their members who purchased health plans through the Affordable Care Act insurance exchanges. ICD-10-CM codes are expected to have an impact on the risk scores that result from these new audits. Providers can expect more clinical documentation requests next year from payers to support their risk adjustment analysis if the ICD-10-CM codes they have on claims do not match with historical diagnoses or other information. Ensuring documentation always supports the billed codes is essential to minimize the disruption caused by the payer records requests.

## Conclusion

Despite the calm transition to ICD-10 so far, it is clear the 12-month claim-denial grace period offered by CMS is a significant opportunity for

providers and payers to ensure the transition to the new coding set remains smooth come next fall. The best part: Accurate coding doesn't just avoid a lot of denial and auditing expenses for providers and payers down the road, but also helps claims to be paid more promptly, which improves cash flow for providers and can streamline operations for both providers and payers. When coders receive fewer rejections and resubmittals, it also means better employee morale and payer relations.


1. Tony Hagen: "ICD-10 Blows Over Like Y2K" *OncLive Online*. November 3, 2015. Available at http://bit.ly/1Rn99QF
2. Greg Slabodkin: "Payers, Clearinghouses Say ICD-10 Going Well" *HealthData Management* online. October 13, 2015. Available at http://bit.ly/22ofbFQ
3. CMS: "CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10 Frequently Asked Questions. Available at http://go.cms.gov/1NScOnT
4. AAPC: ICD-10 Code Translator. Available at https://www.aapc.com/icd-10/codes