

# ICD-10: A DISASTER OR A NONEVENT?

Preparation and accurate coding are the keys to survival and success.

BY MITCHELL A. JACKSON, MD



A medical classification list from the World Health Organization (WHO), the International Statistical Classification of Diseases and Related Health Problems (ICD) is used by many countries worldwide mainly to track new diagnoses and epidemiological trends. Because most of these other countries use a universal

health care-type of approach to payment, the ICD is really a data-gathering system on diseases and disease subclassifications.

In contrast, the United States uses a national Clinical Modifications (CM) of ICD that includes much more detail for diagnostic coding and uses a Procedure Coding System (PCS) for inpatient hospital procedure coding, which can have up to 68,000 (CM) and 76,000 (PCS) codes compared to the 14,400 codes in the 10th revision of the ICD (ICD-10) alone in other countries. ICD-9-CM itself had only 13,000 codes. The ICD-10-CM and ICD-10-PCS went into effect in the United States on October 1, 2015. Ironically, ICD-10 is itself 25 years old, having first been adopted by WHO in 1990, and some other countries started using ICD-10 in 1994. ICD-11 is in development now, and WHO plans to release this update in 2017.

The US government decided to use this epidemiological system of tracking data as a coding system to include detail that ICD-9 could not capture. ICD-9 codes are based on three to five letters and numbers, whereas ICD-10 codes are based on three to seven letters and numbers. At first glance, it appears that the ICD-10 transition was a nonevent after proper preparation and consulting guidance. My practice used specialists such as Patricia M. Morris, COE, from Excellence in Eye Care Leadership Support ([www.4pmcoe1.com](http://www.4pmcoe1.com)). She has provided my practice with appropriate support for electronic health record (EHR) integration, ICD-10 transition, and meaningful use attestation. For practices not using EHR software, however, I expect that the transition to ICD-10 has been more daunting, owing to the nearly sixfold increase in codes.

Here is my initial assessment of ICD-10.



## PRODUCTIVITY AND IMPACT OF CLAIM PROCESSING

Providers should expect revenue challenges in terms of delays from both public and private payers. Initially, I would anticipate decreased productivity because of the increased time required for proper documentation using specific eye codes. Physicians, billers, and coders will take additional time to locate and sequence the appropriate codes based on documentation. Coding errors include incorrectly assigned unspecified codes, codes of lesser specificity, and missed diagnostic codes. For example, simply forgetting to document whether or not a diabetic patient uses insulin as part of a comprehensive eye examination can be problematic with the new ICD-10 system.

## INCORRECT EHR OR APPLICATION CODE MAPPING

Many mapping tools do not drill deeply enough for the fourth through seventh digits. Also, because there is not always a one-to-one mapping between ICD-9 and ICD-10, mapping tools may not be able to provide the definitive code for a given situation. There may be an application for a specific code, but the provider will still need to refer to the ICD-10 coding manual. The delays in billing claims ultimately increase the number of days in accounts receivable and

## HOW TO MAKE ICD-10 WORTH THE TROUBLE

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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 the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (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. 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.

can adversely affect the practice's cash flow. Before ICD-10 went into effect, the US government warned practices to consider taking out credit loans to buy the time needed until delayed claims were finally processed and paid. Luckily, with the help of a consultant, my practice did not have to go this route and has survived the transition at the 6-month time point.

### COMPLIANCE AND DOCUMENTATION

More than just revenue cycle or billing and coding, the transition to ICD-10 affects practice compliance. With an increasing focus on pay for performance and medical necessity, providers must ensure that the medical record (paper or electronic) contains enough specificity for the selection of the ICD-10 code that reflects the condition at hand. Many conditions are listed as right eye, left eye, bilateral, or unspecified, and others are further differentiated as affecting

### 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.

### THE FUTURE

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.

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the right upper, right lower, left upper, or left lower eyelid. For glaucoma, a seventh character denotes the stage of the disease. Postoperative complications must also be clearly defined. In general, laterality and ordinality must be specified, and the details of how a corneal abrasion occurred, for example, need to be spelled out and processed accordingly.

### REPORTING

Practices must adjust and revise reports to account for the new codes. This transition affects all types of data mining—from financials to quality assurance to recalls. It is essential to examine and revise internal policies and processes in order to ensure that quality patient data are captured. In a survey of 200 physicians, 86% claimed that the time required to address technical issues, payment problems, and coding snags after the implementation of ICD-10 negatively affected patients' care.<sup>1</sup>



## AT A GLANCE

- Initially, a practice's productivity may decrease because of the increased time required for proper documentation using specific eye codes.
- More than just revenue cycle or billing and coding, the transition to ICD-10 affects practice compliance.
- Close monitoring of the revenue cycle and a reassessment of internal processes will help identify gaps during the transition.
- 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.

### WHAT TO DO NEXT

Not only does accurate ICD-10 coding affect a practice's financial health, but it is also directly tied to patients' outcomes. Proper planning is key to compliance and optimal revenue management. Continuing education and the employment of certified, qualified, experienced coders will

minimize coding errors. My practice's current coders attended at least three ophthalmology-specific coding seminars in advance of the October 1, 2015, transition date.

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### CONCLUSION

Although ICD-10 seemed to herald impending disaster, proper planning and preparation have made the transition a nonevent for my practice. Medicare, Medicaid, and the key commercial payers such as Blue Cross/Blue Shield, UnitedHealthcare, Aetna, and Cigna all seemed to be prepared as well, which helped significantly. That said, I fear that the United States' pay-for-fee system will remain in this epidemiological tracking system for coding when WHO releases ICD-11 and ICD-12. ■

1. DiChiara J. 86% of physicians say ICD-10 diverts focus from patient care. RevCycle Intelligence website. Published October 14, 2015. <http://bit.ly/1PFaQTq>. Accessed February 11, 2016.

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