ICD-10-CM Troubleshooting Q & A
Agenda

- Next steps with ICD-10-CM
- Coding clarifications
- Claim rejections and denials
- Payment disruptions
- 2016 Changes
Next Steps with ICD-10-CM
Keep Watch

- Continue to submit claims daily. Not submitting claims in a timely manner may delay payment.
- Monitor rejections through the clearinghouse and understand the cause. Use as training opportunities.
- Monitor electronic claim submissions are being accepted and processed timely.
- Be aware of any payer policy changes affected by ICD-10.
- Check CMS-1500 claim forms 3 weeks after mailing to ensure payers are accepting and processing claims.
- Watch for payment delays.
- Watch for changes in the “rhythm” of the A/R, any negative changes investigated right away. Be Proactive.
Stay on Track

- Good communication with team
- Contingency plan and when to implement
- Be proactive, keep on top of issues impacting the cash flow (denials, rejections, overall production)
- Be consistent in billing processes and stick to established deadlines to complete tasks (daily, weekly, monthly)
Metrics to review

- Compare production October 2014 to October 2015
- A/R reflects same rhythm, any jumps or changes need to be investigated
- Payer mix report; show a breakout of charges, payments and adjustments by insurance payer/plan
- Track monthly denials, including the dollar amount. Use the causes as training opportunities and track improvement
The total days in accounts receivable

The Total Days in A/R - is the average number of days it takes to collect the payments due to the practice. To calculate days in A/R,

**Part 1:** Take total charges for last 6 months / number of days in the last 6 months = average daily charge

**Part 2:** Total outstanding A/R to date / average daily charges (from part 1) = days in A/R

Example:

**Part 1:** Total charges for the last 6 months is $280,000 / 182 number of days in the last 6 months = $1,538 average daily charges

**Part 2:** Total outstanding A/R is $70,000 / $1,538 average daily charges = 45.5 days in A/R

Benchmarks for billing processes:

- 20 - 30 days or less for high performing billing processes
- 40 - 50 for an average performing billing processes
- 60 days or more for below average billing processes
Days in A/R for over 120 days
• Divide the dollar amount of accounts receivable that is greater than 121+ days by the dollar amount of total outstanding accounts receivable
• Multiply by 100

Example: \((\text{total receivables greater than 120 day/total receivables}) \times 100\)

Receivables 121 to 150 days = $10,000
Receivables 151+ days = $5,000
Total receivables: $180,000

\[
\frac{($10,000 + $5,000)}{($180,000)} \times 100 = 0.08333 \times 100
\]

Receivables greater than 120 days: 8.33%
Claim Rejections and Denials
CMS Medicare Alerts

Routine Eye Exam Claim Denials

**Applies to:** Providers billing routine eye exams

**Procedure Codes:** 92002, 92004, 92012, 92014, 92018-92020, 92060, 92065, 92070-92072, 92081-92083, 92100, 92120, 92130, 92140, 92230, 92235, 92240, 92250, 92260, 92265, 92270, 92275, 92280, 92283-92287, 92310-92317, 92325-92326, 92330, 92335, 92340-92342, 92352-92355, 99201-99205, 99211-99215, 99241-99245, 99251-99255, 99261-99263, 99271-99275, 99301-99303, 99311-99316, 99321-99323, 99331-99333, 99341-99343, 99347-99353

**Background:** Eye exam visits containing ICD-10 diagnoses that are considered to be routine/non-payable diagnoses are denying when the routine/non-payable diagnosis is not billed on the detail line of the eye exam visit but is being billed elsewhere on the claim. The claims processing system should be set up to deny eye exam visits only when the routine/non-payable diagnosis is billed on the detail line.

**Noridian Action:** On 10/14/15, Noridian updated the claims processing system and began testing. Once testing is completed and implemented into Production, mass adjustments will be completed for affected claims.

**10/26/15:** The claims processing system has been updated and tested. The new claims should process correctly. A mass adjustment for the affected claims is scheduled to begin between 10/28/15 - 10/30/15.

**Provider Action:** None

**Date Reported:** 10/14/15

**Date Resolved:**

**Last Updated Oct 26, 2015**
CMS and AMA Joint Announcement (updates Sept. 22 2015)

- The CMS Ombudsman is in place
- Allow a 12 month transition offering flexibility, if a valid ICD-10 code from the right family is submitted
- Medicare will process and not audit valid ICD-10 codes
- Will overlook specificity
- However, claims will be denied if the code is not consistent with an applicable policy, such as LCD (check w/ local MAC) or NCD
Claim acknowledgement rejections

• ICD-10 code is not a valid ICD-10 code or is not valid for the Date of Service reported
• Diagnosis code must not contain a decimal
• ICD-10 codes that begins with letter “V”, “W”, “X”, or “Y” are not allowed.
• Cannot have both ICD-9 and ICD-10 codes on the same claim. If principal diagnosis code is an ICD-9 code then subsequent diagnosis code must be an ICD-9 code.
• ICD-9 qualifiers and ICD-10 qualifiers cannot be on the same claim.
• Invalid ICD-10 diagnosis code.
“Family” of Codes

“Family of codes” is the same as the ICD-10 three character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition.

Example:

- **H52** - Disorders of refraction and accommodation (family - invalid)
- **H52.1** - Myopia (subcategory) Invalid; 5 digit
  - **H52.11** - Myopia, right eye (valid)
  - **H52.12** - Myopia, left eye (valid)
  - **H52.13** - Myopia, bilateral (valid)
Valid vs. Invalid Code

To be a valid, ICD-10-CM diagnosis code must be coded to the full number of characters required for that code.

Example:

H01 - Other inflammation of eyelid (family)
H01.0 – Blepharitis (subcategory)
H01.00 – Unspecified blepharitis (invalid - 6 digits required)
  H01.001 - Unspecified blepharitis, right upper eyelid (valid)
  H01.002 – Unspecified blepharitis right lower eyelid (valid)
  H01.003 – Unspecified blepharitis right eye, unspecified eyelid
  H01.004 – Unspecified blepharitis left upper eyelid (valid)
  H01.005 – Unspecified blepharitis left lower eyelid (valid)
  H01.006 – Unspecified blepharitis left eye, unspecified eyelid
CMS / Medicare Resources

- Check local MAC for Alerts
- www.roadto10.org
  - www.cms.gov
    - icd-10
      Medicare Fee-For-Service provider resources
- ICD10ombudsman@cms.hhs.gov
Coding Clarifications
Coding Tips

- CPT coding is not affected by the ICD-10 change
  - Process for determining correct CPT codes are the same as with ICD-9
  - Modifiers remain the same, including eye modifiers (RT, LT)
- Be clear on a valid vs. invalid codes
- Look up term/condition in the Alphabetic Index, then verify code in Tabular List
- Pay attention to the coding notes and direction in the Tabular List
- Code only valid ICD-10-CM codes, include all required (3, 4, 5, 6, or 7) character
Vision Examination

**Z01.00** Encounter for examination of eyes and vision without abnormal findings

**Z01.01** Encounter for examination of eyes and vision with abnormal findings

- Abnormal finding need to be clearly documented and additional codes utilized on the claim
- Both codes will likely be processed as a vision exam and not a medical exam.
Good documentation includes

- Reason for visit or chief complaint with relevant history
- Exam findings
- Diagnostic testing results or findings
- Assessment
- Clinical impressions
- Plan of care
Documentation Tips - ICD-10-CM

- ICD-10-CM will require more specificity
- Type of condition should be documented when known
- Unspecified code can be used but should be used rarely
- Unspecified laterality codes should not be used, indication of lack of documentation
Other and Unspecified Codes

Other Codes
Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate “other” codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.

Unspecified Codes
Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. Documentation does not include enough information to code with level of specificity required by the code.
Signs and Symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

(R51 - Headache - Facial pain NOS)

Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
Documentation Tips - Ocular Injury

- There is no national mandate that external codes are required
  - State agencies and specific payer policies that may require
    - Workers Comp.
- External cause codes are always secondary codes
- Combination external codes exist
- Documentation should tell a story of incident
Payment Disruptions
Payment Disruptions

• Keep in mind, ICD-10 codes do not drive the reimbursement. Reimbursements are derived by the value of the CPT code therefore all reimbursement amounts remain the same as prior to October 1\textsuperscript{st}. Review payment vouchers regularly and inquire if there are any discrepancies

• Consider adjusting the frequency in working the accounts receivable to a daily or weekly basis instead of a bi-weekly or monthly basis. This will allow for quicker resolutions of the current claims, but also help avoid future denials as well

• At what point is it necessary to implement contingency plan
Changes in 2016
2016 Changes

- No changes made to ICD-10-CM code set for 2015
- Changes to Meaningful Use and PQRS reporting
- Check for payer policy changes
- Medicare fee schedule changes
- Deductibles will begin again
Continued Discussion on Troubleshooting ICD-10

- Next PECAA webinar on part 4 of the ICD-10-CM series is December 17, 2015.
  - Continue to monitor ICD-10 issues
  - 2016 Changes
    - Medicare updates including 2016 fee schedule
    - Any new policy, coding changes or revisions
Questions
Thank you!

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