4 steps to optimize post-ICD-10 transition success

By Ken Bradley, MGMA member

Many healthcare experts compared the ICD-10 transition to a severely catastrophic Category 5 hurricane — not only because it represented major change, but also because it required extensive and multifaceted preparation efforts. With multiple sources anticipating large increases in denials and rejections, healthcare organization leadership and staff were understandably anxious. In an August 2015 survey of physician practice leadership, 94% of respondents anticipated an increase in denial rates, and 56% said their greatest concern was ICD-10's effect on revenue and cash flow.[1]

When Oct. 1 arrived, however, the majority of healthcare organizations remained productive and maintained financial success. In fact, according to a post-ICD-10 implementation survey from December 2015, 99% of respondents indicated they were prepared for the transition on Oct. 1.[2] When it comes to the enormity of change it represented, ICD-10 certainly remained a Category 5; however, provider preparedness kept it from being catastrophic.

Physician practices were rewarded with a double dose of good news early after the ICD-10 transition date and, for the most part, they were successfully submitting claims and getting paid. While these wins were worthy of celebration, physician practices can continue to maximize claims reimbursement and ensure ongoing ICD-10 success with the following four steps:

1. **Conduct an analysis of denials.** Nearly 90% of respondents to the ICD-10 post-implementation survey indicated denial rates remained the same or increased less than 10%. However, the effect of denials can take longer to see or measure. Some industry members saw less than a 4% increase in denial rates in November and a return to historically average rates in December. While every organization has unique data and unique ways of interpreting the data related to denials, now is the perfect time to conduct a thorough analysis of your top denial reasons since you should have several months' worth of data to assess. Watch for new top denial reasons as a result of ICD-10.

Create and rank up to 10 categories, such as missing information, incorrect coding and eligibility, from highest count to lowest in terms of denials. Then group those caused by the practice, payer and those that are expected such as contractual agreement adjustments. Track your statistics for each category and include at least three months of pre-ICD-10 data to compare with post-transition data. This data can help you identify necessary process improvements, such as how payer requirements for referrals are collected, stored and used, and additional training to reduce denials and increase claims revenue.

2. **Assess clinical documentation.** Since ICD-10 competed with many priorities, it might have been difficult to schedule training. A post-ICD-10 review of clinical documentation can help you identify areas for improvement and potential audit red flags. As you conduct chart reviews, keep a list of everything that should be included to support the highest level of specificity that ICD-10 provides and ensure that your clinical documentation contains this necessary information. In addition to reviewing documentation, track statistics related to coder queries. Review accuracy and length of time per query along with the number of queries per month. Determine whether each metric has continuously improved each month since October 2015.
3. **Ensure the most accurate use of codes.** While you're assessing clinical documentation, review coding in tandem to help determine whether you're using the most accurate codes for claims submission. When a code is accepted by a payer, you know it's valid. What you might not know initially, however, is whether the code is accurate based on the care encounter. Regardless of preparedness, all physician practices need an adjustment period due to the sheer number of codes in ICD-10. This is the ideal time to review documentation alongside claims for top diagnoses to determine whether your coding is correct and accurately represents care given.
4. **Launch a post-ICD-10 review.** For the first 60 or 90 days after Oct. 1, practices tackled the issues foremost on leadership's minds: submitting error-free claims while achieving volume and productivity levels akin to what they sustained with ICD-9. Now, however, practice leaders can conduct a review of front-, middle- and back-office teams to ensure they're all fully ICD-10-compliant and as efficient as possible. Include a feedback loop to collect team feedback and ideas for your next initiative. Also, make one final review of information technology systems. Now that the initial flurry has passed, you could ask whether any features, functionality, menus or screens can undergo further optimization to help streamline processes or reporting.

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Our post-ICD-10 implementation survey respondents listed their top 2016 priorities as optimizing revenue cycle management, working toward a value-based care model and automating patient collections. Physician practices achieved a successful ICD-10 transition due to planning and prep work, but the work is far from over. Data from the first post-transition months can help you optimize revenue by identifying denial and rejection trends. As practices balance a hefty list of priorities, keeping ICD-10 in the mix can enable them to build upon a successful transition and stay on track to achieve clinical and financial benefits. ■

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Notes:

1. Navicure. Healthcare organization ICD-10 readiness survey. August 2015. Available from: mgma.org/icd-10-prep.
2. Navicure. Healthcare organization post ICD-10 implementation survey. December 2015. Available from: mgma.org/icd-10-survey.