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ICD-10 Is Not Scary (and Not About Billing)

WHAT YOU SHOULD – AND SHOULDN'T – BE WORRIED ABOUT AS THE OCT. 1 DEADLINE APPROACHES.

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In my 13 years of consulting with doctors on billing and coding matters, ICD-10 has aroused the biggest combination of misguided fear and ignorance I can remember. The good news is if you weren't prepared for ICD-10 last year, you were rewarded with an additional 365 days to get your act in gear. Unfortunately, the more I travel and speak around the country, I find the majority of our profession is yet to even start preparing to even look at the codes.

This time around, it doesn't look as if implementation of the new ICD-10 codes will be delayed beyond the October deadline looming just a few short months away. Let's learn more about what ICD-10 entails and what doctors of chiropractic need to focus on in order to make a smooth transition.

Misguided Fear #1: Confusing New Codes

To be honest, there is really nothing to be fearful about when it comes to the new diagnosis codes: They're only billing codes, and anyone can pick a billing code and put it on a claim form. In addition, conversion of the codes has already been done by CMS and is free to anyone who wants it, which makes the process of converting your current code list even easier.

The conversion tool is called GEMS, or General Equivalent Mappings, and the familiar "subluxation" diagnosis codes we've used since 1988 are actually nothing more than a one-for-one swap in the new configuration. This means the 739.1 (cervical segmental dysfunction) code is simply going to be replaced by M99.01. There are no left or right modifiers or active care versus maintenance care codes here. For the subluxation diagnosis, it is just a simple one-for-one switch.

Recently, I reviewed codes for our own EHR customization program and found that of the 50 most commonly used ICD-9 diagnosis codes, a whopping 55 percent of the codes are not expanded or made more complex by splitting them into two or more different diagnosis codes. So, are the codes extremely confusing? The simple answer is, not really. One of the best (and free) GEMS conversion tools is called "Find-A-Code," and is available on both i-Tunes and Google Play.

Misguided Fear #2: Claim Denials ... Imprisonment?

The next interesting issue when it comes to ICD-10 is the fear of claims being denied by CMS because of the wrong Dx or people getting audited and going to jail. Can someone tell me where all this talk about going to jail is coming from? Currently, doctors are not going to jail because of use of incorrect diagnosis codes - so why would things change after Oct. 1? My 2 cents are that none of this is going to happen after the implementation date. My rationale comes from a July 6, 2015 CMS release in which this issue was directly addressed:

CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10: Frequently Asked Questions

Q. What happens if I use the wrong ICD-10 code, will my claim be denied?

A. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated

medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

So, what will CMS do if you use the wrong code or a code that is not specific enough (but still a valid code)? According to the release, all CMS will do is pay the claim in exactly the same way claims are paid today. All of this is meant to give providers time to get better at choosing the best "correct" code. (In my opinion, this might not be the best thing for doctors if they don't continue to work toward refining their coding and just fall into the trap of believing that if their claims are paid, they must be doing everything right.)

The Real Issue: Our Need for Proper Documentation

But even if we do get paid, that still leaves chiropractors with the biggest problem we face as a profession: documentation. Chiropractors will have to address their overall level of documentation when it comes to using the new ICD-10 codes. Yes, choosing a code won't be hard with the GEMS at your disposal, and CMS will even let coding issue go for a little while before everyone is expected to get it right at the time the claim is submitted. As I see it, the problem is what will happen when the review does come and the notes don't support the code we so easily chose.

The thought of a review based upon using the new ICD-10 codes takes me back to my high-school days when I took algebra. In algebra, the rules were, "Answer the question *and* show all your work." I distinctly remember that if you didn't show your work, you got *zero* credit. This is how ICD-10 codes will be different when Oct. 1, 2015 rolls around: When you choose a diagnosis code, you will need to "show all your work" in your notes to support the reason why you used the code in the first place.

A great example of this is when a doctor only states the patient has sciatica. The doctor might not say anything else in his exam or history other than that the patient complains of radiating leg pain. In ICD-9, the doctor could use the sciatica diagnosis code and then add in a disc diagnosis because of the patient's complaint.

The fix doctors will need to understand in order to *prove* the use of the new codes is "Direct Therapeutic Relationship." Yes, this comment comes from Medicare's definition of medical necessity, but it applies to proving diagnosis codes. In order to "show your work," doctors must connect the complaint to the test. The test and its result must be connected to the diagnosis. This is the work you must show and what insurance companies will be looking for if your claims get chosen for review.

Two Important Steps to Take – Starting Today

The first step you'll need to take to start the transition to ICD-10: convert your current code list to ICD-10. The second and most important step: write down all of the corresponding documentation that supports each diagnosis. The second step is the one that will take the longest. My team has been working for 18 months on the conversion of 100 of the most commonly used diagnosis codes. The codes did swell from 100 to just over 300 codes, but the part that has taken the longest is researching and writing up the supporting documentation for each diagnosis code.

So, if you've waited to get started, let this be your wake-up call to improve your documentation that will support the codes you chose. Documentation will be (and has been) the focus of claim review.

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