ICD-10: How Ready are You for the October 1, 2015, Deadline?

Code Shift Creates Opportunity to Address Referral Shortcomings

It's an enduring problem for pathology and radiology practices: A patient arrives from a referring physician with a requisition for lab work or imaging services. But because the service provider has no way to verify the diagnosis code that's included with the request, there's a chance the information is incomplete or incorrect. The result is a potential denial and zero payment for the service rendered.

"Basically, the radiology group or lab is at the mercy of the individual or practice that is sending the patient to them," said Bess Ann Bredemeyer, a consulting director with McKesson Business Performance Services (BPS). "If the diagnosis code is faulty, it will prevent the lab or imaging group from being reimbursed. Yet most can't simply refuse to provide the service, so they have to take a chance. But it can end up costing them. It's a very common problem and a real thorn in the side for a lot of practices."

A Vehicle for Process Improvement

The good news is that the coming ICD-10 coding transition creates an opportunity for groups to address and resolve this dilemma. By working first to identify physicians who repeatedly provide incomplete or incorrect diagnosis codes, practices can use broader discussions surrounding the ICD-10 transition to highlight the issue and to develop a process for reducing or eliminating the faulty codes.

Dealing with the problem before ICD-10 takes effect is essential, Bredemeyer said, since the issue will likely only get worse once the new, more complex code set is operational.

"If referring physicians are not providing what you need with ICD-9, you can be pretty sure they're not going to give it to you with ICD-10," she said. "And because ICD-10 is going to impact so many other areas of the revenue cycle, particularly in terms of productivity, there is no reason to wait to resolve this. It's something you can do right now."

Making a List

So what steps should a practice take to mitigate faulty referral codes? Bredemeyer says the first step is to review denials in order to create a list of "repeat offenders," or practices that most frequently submit problematic codes.

Intake personnel should check referrals against the list to determine if the diagnosis code may be suspect. A process can be created to immediately route the requisition back to the doctor's office or even call them directly with a request for a code correction or clarification.

But because a timely response cannot be ensured, the most effective approach may be to arrange meetings with the appropriate personnel at the practices in question, including potentially practice managers or medical directors. The stated agenda should be to discuss how ICD-10 would impact referrals from the practice. It may be beneficial to provide a list of the most common ICD-9 codes used in referrals from the group, along with the equivalent ICD-10 codes.

Quantifying the Problem

The referring group should also be provided with examples of faulty diagnosis codes used in the past. Statistics should reflect the frequency of the denied codes, their total number over a specific period of time, the individual physicians involved and how the denials were resolved, be it through a write-down by the service provider or balance billing to the patient.

"Once you've laid out the full scope of problem to the practice, including the cost to your organization as well as the impact on their patients, you've effectively put them on notice to resolve the issue," Bredemeyer said.

She added that you should emphasize the importance of dealing with the matter ahead of the ICD-10 transition, since denials will most likely spike in the immediate aftermath of the changeover.

Because payer medical necessity edits will also be changing with ICD-10 transition, it will be critical for practices to determine if fault for a denial lies with the providers or the payers' new edits. By eliminating or reducing denials caused by faulty diagnosis codes, identifying the actual reason for the denial and resolving it will be much easier, Bredemeyer stated.

Open Communications

If problems persist, practices can create easily modified template letters to send out to physicians or practices that describe the nature of the faulty diagnosis code or codes (and that remind them about previous discussions on the matter). Finally, practices may want to consider establishing a written protocol wherein referring groups are required to systematically verify and cross-check their diagnosis code before requisitioning a service.

Whatever approach is taken, Bredemeyer said, it is important to communicate "early and often" with referring practices.

"Think of ICD-10 as an opportunity to strengthen relationships with your referring physician groups," she explained. "Once communication channels are open, it becomes much easier to create a process to solve the problem, and to follow up to make sure that it doesn't continue to occur."