ICD10Central

Screen Shots for Publication

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ICD10Central.com – Home Page

ICD10Central.com is designed to help providers understand where they stand relative to industry norms, identify and resolve problem areas quickly, get fast answers to pressing questions and shore up their revenue cycle practices to help minimize denials and other problems in the immediate post-transition period.

ICD-10 Central | Any Questions?

HOME | ICD-10 METRICS | CODING GUIDANCE | PAYER PANEL | BEST PRACTICES FORUM | OUR SOLUTIONS

Making Sense of the CMS/AMA ICD10 Stance

What it Means	What it ALSO means
A valid ICD-10 code is required	Coding outside of ICD-10 family of codes is subject to denials
Medicare Part B claims - physician & 1500 only - will not be denied when using the wrong ICD-10 code	Inpatient hospital claims are not exempt from denials/incorrect reimbursement
Claims billed through automated or complex medical reviews may be exempt from denials	All other methods can and may be denied
Quality reporting penalties may be exempt in certain cases (i.e., Physician Quality Reporting System, VBM Meaningful Use)	Correct ICD-10 family of coding is required to avoid quality reporting denials
An advanced payment may be available from CMS in the event of administrative errors	Processing errors have to be on CMS side for advanced payments to be issued (not when Physicians are unable to submit)

And last but not least, ICD-10 is STILL coming October 1, 2015!

RelayHealth processes **3.3 billion** healthcare financial transactions between providers and payers annually. We are **driven to provide innovative solutions that help customers succeed** in the business of healthcare.

Root Cause Comparative Data Engages Physicians to Accelerate Cash

Silverton Hospital's service-to-submission rate was averaging weeks rather than days when organization leaders sought a solution that would provide insight into issues creating the delay. The solution they needed would help the organization grasp hot spots at a glance while comparing performance both within the organization and to best practices versus similar hospital peers.

See the solution that helped Silverton's leaders ensure accurate comparisons of behaviors and timeframes with standardized methodology, and provided consistent comparisons to similar hospitals. Find Out More About RelayAnalytics Pulse Here

Testing Results Highlight Common Problem Areas

During Medicare end-to-end testing, the largest issue found was related to days-not-final-billed (DNFB). In other words, **providers had trouble producing a clean claim** that could be submitted. See where you can use payer testing results to find out which areas you may encounter problems come October 1st.

Read More

Establish Visibility Into Performance

Beginning October 1, industry sources say providers could experience declines in performance related to an increase in Denials, Days in A/R, Claim Error Rates, and a significant decrease in Coder Productivity. Establishing visibility into local performance and industry performance can help you stay on top of your game.

Read More

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ICD-10 Metrics

Examining the data from 3.3 billion transactions and 2,430 hospitals flowing through its network, RelayHealth Financial identified four KPIs most likely to be impacted by the transition: Days to Final Bill, Days to Payment, Denial Rate and Reimbursement Rate.

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Select Healthcare Specialty: Cardiology | OB/GYN | Orthopedics | Radiology | ALL

Select Your Region: Northeast — Select Estimated Bed Size: 100 - 249 Beds

Metric	May	Jun	Jul	August 1 - 6	Last 7 Days, Jul 31 - Aug 6
Days to Final Bill (Days)	14.5	14.5	14.7	13.2 Days	14.3 Days
Days to Payment (Days)	42.4	45.6	39.0	39.8 Days	40.1 Days
Denial Rate (%)	1.7	1.5	1.8	1.9%	1.7%
Reimbursement Rate (%)	32.0	28.8	30.2	30.7%	29.5%

All Critical KPIs For RevCycle

Need real-time* visibility into your performance?

Find Out How

Days to Final Bill (Days) — Last 7 days

May 14.5 | Jun 14.5 | Jul 14.7 | August 1 - 6: 13.2 Days | Jul 31 - Aug 6: 14.3 Days

Days to Final Bill The number of days from statement through date until claim was submitted to RelayAssurance for primary claims only.

This KPI allows organizations to measure the impact of the hospital's time to capture and code charges to the overall Days in A/R. The need to capture late charges, increased physician query, new documentation specificity requirements, physician charting delays, and decreased coding efficiencies will increase the DTFB. The DTFB increase slows cash flow and increases the AR days for the facility or practice.

Below is a report example that illustrates the breakdown of DTFB for Institutional and Professional claims. Each claim form type is further broken down by Primary and non-Primary claims to help health systems identify the timeliness of internal processes (secondary claims usually have a payer dependency). This report can additionally drill down into Admission Type and Specialty to help you monitor your performance of invoicing claims by areas of business.

99998 - COMMON MERCY HEALTH

1500 (Professional) — Primary Claims Service to Submission; Non-Primary Claims Service to Submission

UB (Institutional) — Primary Claims Service to Submission; Non-Primary Claims Service to Submission

** For more information on how to view this report with your own data, check out Acuity under the "Our Solutions" tab.

DISCLAIMER: The information provided above is for illustrative purposes only.
* Data in RelayAnalytics solutions is updated at least once daily.

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These key metrics are continuously monitored and updated on ICD10Central.com– enabling visitors to easily identify trends over time, gauge their own performance, and take corrective action as needed.

ICD-10 Coding Guidance

ICD10Central.com illustrates 12 common and potentially problematic diagnosis/procedure codes each for four specialties–Cardiology, Orthopedics, Obstetrics, Radiology–plus a “catch-all” category in both ICD-9 and ICD-10 coding to show complexities and trouble spots.

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Select Healthcare Specialty: Cardiology | OB/GYN | Orthopedics | Radiology | Other

Other and Unspecified Angina Pectoris
07/28/15

Cardiac Complications
07/22/15

Other Complications Due to Other Vascular Device,
07/22/15

Other Complications Due to Heart Valve Prosthesis
07/22/15

Mechanical Complication of Other Vascular Device,
07/22/15

Mechanical Complication of Cardiac Device, Implant, and
07/22/15

Need real-time* visibility into your performance?

Find Out How

Other and Unspecified Angina Pectoris - 413.9 07/28/15

*DRG Shift Med

Expanded to include angina caused by atherosclerosis. Atherosclerosis is specified in native artery or type of graft. Presence of documented spasm and transplanted heart is also specified.

Angina without atherosclerosis is assigned the same DRG 311 as the ICD-9 code. Angina with atherosclerosis is assigned to DRG 302 or 303, both of which have a higher weight than DRG 311. Therefore there is a positive DRG shift in cases of angina involving atherosclerosis.

Potential ICD-10 Code	Description	*Clinical Documentation Improvement* = CDI
I20.8	Other forms of angina pectoris	
I20.9	Angina pectoris, unspecified	CDI
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm	CDI
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm	CDI
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris	CDI
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris	
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm	CDI
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris	
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm	CDI
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris	
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris	
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm	CDI
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris	
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris	
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm	CDI
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris	
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris	

Payer Panel

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CareFirst 07/27/2015

Health Alliance 07/22/2015

Meridian Health Plan 06/18/2015

CareFirst

ICD-10 Authorization Review Request GuidelinesICD-10 Claims Submission Guidelines

Introduction

The U.S. Department of Health and Human Services (HHS) has released a HIPAA administration simplification mandate requiring all HIPAA entities to adopt the 10th revision of the International Classification of Diseases (ICD-10) code set on October 1, 2015.

This document will provide direction to providers regarding CareFirst acceptance of medical claims for professional services and facility charges before, during, and after the October 1, 2015 transition to the ICD-10 code set. The guidance in this document applies equally to all claims, regardless of paper or Electronic Data Interchange (EDI) submission channels.

Any claim submitted by a provider that does not comply with these guidelines will be rejected/denied. Providers will be required to re-submit these claims after complying with these guidelines.

To view full article in PDF format, Click Here.

7/27/2015

CareFirst

Provider Frequently Asked Questions (FAQs)

Will CareFirst be ready for the ICD-10 transition?

Yes. We are currently on-track with preparations, and we will be ready for ICD-10 by the October 1, 2015 transition deadline determined by the Centers for Medicare and Medicaid Services (CMS). We have completed our system changes, and are performing internal testing of these updates.

Will CareFirst participate in end-to-end testing of ICD-10 claims with Providers?

Yes. We will perform end-to-end testing with our Clearinghouses and a selected subset of Providers that will be determined based on provider type and historical claims submission analysis. We will contact the selected Providers to coordinate testing activities in Q2 2015. Execution of end-to-end testing with Providers and Clearinghouses is planned for Q3 2015.

How will CareFirst contracts change due to the ICD-10 transition?

Contract negotiations occur on a pre-determined schedule that will not change due to the ICD- 10 transition. As provider contracts come up for renegotiation, any changes that need to be incorporated as a result of the ICD-10 transition will be

Payer-provider collaboration will be critical to revenue continuity in the days and weeks leading up to-–and following–October 1st, so ICD10Central.com provides a repository for payers to submit helpful materials for providers to use in their preparations.

Best Practices Forum

With time running short, ICD10Central.com provides an interactive forum where providers, payers, consultants and vendors alike can post questions, answers, comments and advice–and share their experiences and expertise.

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Start a New Thread or Ask a Question

ICD10 Deadline: For Real This Time?
7/23/2015

Can't Perform End-to-End Testing? Alternative...
7/17/2015

Building Relationships With Payers Now Can Ea...
7/07/2015

Establishing Visibility Into Performance
6/18/2015

Keeping Your Eyes on KPIs
6/15/2015

Testing Results Highlight Common Problem Area...
6/08/2015

June Testing Perspectives
6/03/2015

ICD10 Deadline: For Real This Time?

by Joshua Berman, Director of Analytics and ICD-10 at RelayHealth Financial

It's been nearly six years since HHS published the final rule replacing ICD-9 with ICD-10. As we march toward what appears to be the third and final deadline, it's time to reflect on what we've seen, experienced, and learned. Better still, we can use those insights to inform what work remains in the final run-up to October's coming ICD-10 deadline.

In my travels to meet and consult with healthcare providers across the country, the top two questions I'm asked are, "Will there be another delay?" and "What should we really be ready for on October 1?"

Regarding another delay, I believe - but can't say with certainty - that there won't be any further delays. That's because the current timing and politics are such that I believe another delay is not in the cards. Few people would say the delays and additional years have made us any better prepared for the transition. And from an election standpoint, 2015 is an "off election" year. There's little opportunity for another delay to be politicized. 2016 is big election year, and no one wants another ICD-10 delay on their watch. Add to this the chorus of voices opposing further delay, which has gained a lot of traction on social media recently. These all add up to a "real" transition date this year - October 1.

So with just months to go, what should healthcare providers be focused on now to prepare for and minimize the potential impact of reimbursement delays and rejections in the months following October 1? While testing remains an essential part of preparation, now is the time to focus more on payer testing results, and how to mitigate the problems that every provider will face on October 1. One sobering observation I've gleaned from being involved in lots of testing: providers still need to focus on the basics in their own shops. Concentrate on working with doctors to refine medical records. Work with coders to perfect coding and your HIS systems. You may need to code for both ICD-9 and ICD-10 at the same time on October 1 - and after.

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