

# ICD-10 Coding Issues/ Problems

Here's where we're at one year later.

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Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues

ll in all, the year of ICD10 implementation went
rather well, don't you
think? Obviously, there
were some payer glitches that were for the most part resolved quickly. And there were some
Medicare payer glitches specific to
routine foot care coding that didn't.
Given the pre-implementation doom
and gloom hype, though, you and
your practice survived to fight the
next crisis. Congratulations, whew
(wait...is that MACRA I hear knocking at the door?).

So, what were the most common ICD-10 issues and problems that foot and ankle practices reported last year?

## Matching Your ICD-10 Coding to the Payer's "Approved" Edits

As with ICD-9, when a claim is submitted for reimbursement, the payer's processing software uses programmed edits to pay, pend, or reject the claim. Those edits are relatively transparent when it comes to Medicare (they are found in Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and other published Medicare sources), but less transparent (sometimes completely opaque) with non-Medicare payers.

When you submit a claim and get a denial based on medical necessity or coverage, there is a good chance that the issue is a "non-match" of submitted ICD-10 code(s) and the payer's approved list of ICD-10 codes for any given service or procedure claimed. If you think about it, the payer's claim processing software only has three elements for determining a lack of medical necessity. The first is a "non-match" of ICD-10 code(s) to the universe of ICD-10 codes in the software database. The second is a search of the patient's claim history, looking for CPT or HCPCS billing "frequency" issues. The third, and most like-

worked with the Carrier Advisory Committee (CAC) representatives, state associations, and the APMA to quickly resolve the problem by expanding its list of ICD-10 codes. Noridian's problem was similar, but was limited to the processing of claims for qualified routine foot care codes CPT 11055, CPT 11056, and CPT 11057. Several years ago, Noridian had two separate LCDs that governed the billing of the CPT 11055 series of codes. Prior to the transition to ICD-10, Noridian retired its routine foot care LCD. When preparing its software

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ly reason, is a "non-match" of ICD-10 code(s) linkage to specific CPT or HCPCS codes on the claim.

Most foot and ankle specialist offices reported little to no issues with the transition to ICD-10. Unfortunately, podiatrists in states covered by Noridian Medicare and National Government Services Medicare (NGS) who bill routine foot care weren't so lucky. It turned out that NGS crosswalked and programmed an incomplete list of approved routine foot ICD-10 codes into its claim processing software. This resulted in some routine foot care claim denials.

The good news is that NGS

for the ICD-10 transition, Noridian inadvertently failed to include approval edits for qualified routine foot care codes CPT 11055, CPT 11056, and CPT 11057, resulting in denials. Despite identifying the problems, months went by while Noridian attempted to rectify the software error. Approximately four to five months post-October 1, the issue was declared by Noridian to be "fixed" and podiatrists' offices were told to resubmit claims. Doctors did as they were told only to have Noridian, in turn, send them notices that they owed Noridian refunds. Now those same

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doctors are submitting appeals. One can only hope that all the problems have been eliminated by this time.

For those still getting payer claim denials based on ICD-10 coding issues, check to make sure you are 1) submitting a valid code (one that is a complete code listing the required number of characters), 2) coding to the highest level of specificity (avoid vague diagnoses or conditions; avoid unspecified codes when there are codes available that accurately reflect your patient's conditional presentation), and 3) linking the appropriate ICD-10 to a CPT or HCPCS code on your claim.

### Dealing with ICD-10 Impacts on Practice Productivity

Prior to the implementation of ICD-10 in the United States, concerns regarding its impact on productivity abounded. It was not simply paranoia on the part of healthcare providers, coders, and billers, but on the fact that introduction of a new system with 68,000 codes ranging in 3 to 7 character lengths at the same time CMS was stepping up its PQRS and Meaningful Use requirements was going to be a challenge. Also, many looked to Canada's transition as a model for the United States transition, and were concerned.

Long story short, Canada transitioned to ICD-10 over three years beginning in 2001. Every country has its own version of ICD-10, and Canada's is known as ICD-10-CA...with only 17,000 codes (which include both diagnostic and procedural codes) and a maximum of 6 characters. Coders in Canada, according to a study by the Canadian Institute for Health Information, reported difficulty "in mapping the new codes, due to the new data structures, increased specificity, and new concepts introduced in ICD-10 such as combined codes (previously two separate codes"). Bottom line: With increased specificity and detail requirements in ICD-10-CA reporting, initial professional coder productivity loss in medium to large acute care facilities was expected on the order of 50%. The American Health Information Management Association and the American

Hospital Association in a joint report noted that professional codes at a 605-bed hospital one year post-transition to ICD-10-CA returned to 81% of their ICD-9-CA levels for chart review, 79% for surgery coding, and 85% of emergency department coding.

That was Canada. How did the United States do one year post transition? While many predictions were in the 50% loss of productivity range,

a practice needed to code the highest level of specificity for non-Medicare payers, wouldn't they likewise end up billing for the highest level of specificity for Medicare? So, where's the grace in all this?

Regardless, CMS noted that on October 1, 2016, providers will be required to use the "correct degree of specificity" when coding ICD-10 on their claims. That is interpreted as,

### The one-year grace period in effect for ICD-10 announced in the summer of 2015 by CMS and AMA ended on October 1.

overall, a number of foot and ankle practices reported that there was some, but not much, drop in productivity. That may be attributable to the fact that many offices took advantage of the years of delays to reasonably prepare for ICD-10. That included education through seminars, workshops, webinars, and articles; familiarity of the ICD-10 coding guidelines; early cross-walking of most-used ICD-9 codes to ICD-10; reviewing EHR builtin ICD-10 codes and "automated" linkage within that software; developing "cheat sheets"; and trying to figure out how to get as much detail from the doctor to the coders/billers. Having coding tools like the APMA Coding Resource Center (www.apmacodingrc.org) made the transition go easier than many expected.

#### Good-Bye, ICD-10 Grace Period

For those of you who never even realized it, the one-year grace period in effect for ICD-10 announced in the summer of 2015 by CMS and AMA ended on October 1. One of the complaints associated with the "grace period" was that CMS never coordinated a similar grace period from commercial payers. And the majority of those payers did not go along with CMS's "flexibility". One might conclude that essentially the grace period announcement of flexibility was little more than a CMS/AMA public relations effort that probably didn't change much for the average physician's office. Think about it. If

for example, only billing unspecified codes in limited defined instances and ensuring that the ICD-10 codes are unquestionably supported by the medical record documentation.

#### Practice Makes Perfect: ICD-10 Trauma Case (from Codingline)

"I have a 21-year-old patient who had a farm implement wheel fall horizontally on the right foot, causing a traumatic contusion to the great toe, including nail plate disturbance with a displaced fracture of the distal tuft of the distal phalanx. There was the presence of a subungual and digital hematoma with pain in the great toe. I was the first one to see the patient. What ICD-10 code(s) would be appropriate for the above?"

ICD-10 Possibilities (Running the Table):

M79.674 (pain in right toe)

S90.211A (contusion of right great toe with damage to nail; initial encounter)

S92.421A (displaced fracture of distal phalanx of right great toe; initial encounter)

W30.89XA (contact with other specified agricultural machinery; initial encounter)

While all these are relevant to the scenario, S92.421A pretty much stands alone presuming pain and a contusion occurred. The contusion code, however, is a good inclusion Continued on page 46 *ICD-10* (from page 44)

because it describes the condition of the nail and also represents a hematoma. Regarding the "W" code, unless this is a Workers' Comp claim or the patient's particular insurer requires external causes of injury coding, this level of detail does not have to be reported as an ICD-10 code, but should, obviously, be included in the medical record documentation. And finally, a reminder: the 7th character "A" does not mean the "initial encounter" as described by CPT, but "active management" (as opposed to "D", which is follow-up management).

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CodinglineSILVER will continue its Q/A format, but will shift from a twice a day email to a once a day service. Special categories will be set up so you can decide what foot and ankle coding, reimbursement, and practice management topics are of interest you.

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The Day Before the Clinical Con-

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Dr. Goldsmith of Cerritos, CA is editor of Codingline. com and recipient of the Podiatry Management Lifetime Achievement Award.