

Clearinghouse Realities of ICD-10

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Agenda

- I. Introduction of Cooperative Exchange ICD-10 WG
- II. Our Findings – The Realities of ICD-10
- III. Top ICD-10 issues and challenges
- IV. Resolution of issues and challenges
- V. 90 day metrics
- VI. Recommendations for continued success
- VII. Summary of Post ICD-10



What is the Cooperative Exchange?

The Cooperative Exchange is the recognized resource and representative of the clearinghouse industry for the media, governmental bodies and other outside interested parties.

Our member companies represent over 80% of the clearinghouse industry, processing over 4.8 billion transactions annually worth over \$ 1.2 trillion dollars.

We are committed to promote and advance electronic data exchange for the healthcare industry by improving efficiency, advocacy, and education to industry stakeholders and government entities.



Who Are Our Members?



Cooperative Exchange ICD-10 Work Group

- Meeting weekly to share experiences and trends of the ICD-10 Implementation
- Identify Top ICD-10 issues
- Establish benchmarks - metrics
- Early identification of potential issues
- Develop strategies to share and educate the industry on our findings



Cooperative Exchange Workgroup Members

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Monique Hall
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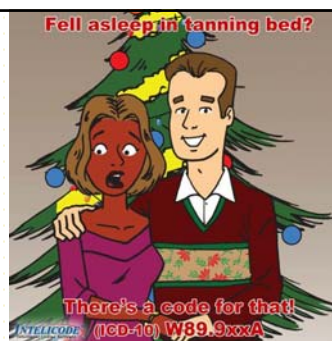
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The Realities of ICD-10

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Statements from our WG members

"We have had very few issues based on the actual ICD-10, it has been more that the Practice Management Software was not ready. We believe testing with the payers helped identify payer issues prior to go live where one issue not being caught before go live could have caused millions of claims to be in error. The one-on-one end-to-end testing with the payers was the key to the success that we have had with the ICD-10 Go Live."

"It was a non event attributed to good ICD-10 planning, education and testing"



The Realities of ICD-10

Statements from our WG members

“Provider readiness proved to be better than expected. We identified issues that were typically isolated and low impact which were quickly resolved. Our analysis showed 50% of the external issues identified were payer related, 25% vendor, and 25% submitter client. Overall, the majority of the industry has transitioned with minimal material impact to date..”



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The Realities of ICD-10

Statements from our WG members

“During the month of October, we helped our clients handle thousands of ICD-10-related support cases. Eighty-five percent of all cases were resolved within the same day, with the majority of ICD-10-related issues attributable to split claims, invalid codes and invalid qualifiers. Our reports show a successful transition to ICD-10, with its clients achieving a first pass clean claims rate of 98 percent.”



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The Realities of ICD-10

Statements from our WG members

"We are extremely pleased with the smooth transition experienced going into ICD-10 as well as post ICD-10 production results for our business, but more importantly, for our client base."

"We are no longer seeing front line rejections as a result of incorrect coding. We haven't seen any real issues after the first 2 weeks of implementation."

"Our ICD-10 program goals were to ensure a smooth transition for our operations and our customers. The goals were met and we are seeing mostly business as usual. In fact, as the ICD-10 claim volume continues to increase very few issues are being reported."

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Top ICD-10 Issues and Challenges

Top ICD-10 Issues & Challenges

- DME span date claim rejections.
- Payer rejections based on External Cause of Injury codes
- Lack of correct specificity.
- Invalid ICD codes
- Payer systems modified for ICD-10 related issues triggered other internal issues not related to ICD-10
- Valid codes rejected due to processing system updates for new codes not in place.
- Legacy format submissions required mapping to be in place

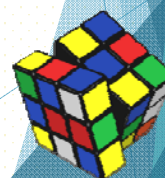


Top Clearinghouse Rejections

- Diagnosis Code(s) is invalid for the date of service performed
- Incorrect diagnosis pointer
- Incorrect qualifiers
- ICD 9 and ICD-10 on same bill
- Claims with dates of service that span the compliance date
- ICD 10 Principal diagnosis code must be present.



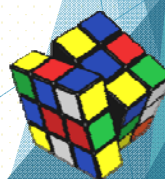
Challenges
Issues



Top Payer Rejections (999/277)

- Split claim
- ICD-10 CODES CAN NOT BE DUPLICATED. Diagnosis Codes (primary and secondary) are expected to be unique within claims
- Payers requiring 3 external cause of injury codes
- Value of sub-element HI01-02 is incorrect. External cause code cannot be used as Principal Diagnosis code
- Diagnosis Code: Invalid; Diagnosis Code must be most specific
- Diagnosis Code: Invalid; Claim contains a mixture of ICD-9 and ICD-10 codes based on the code list qualifiers
- submitted. Claim cannot contain a mixture of ICD-9 and ICD-10 codes

Challenges
Issues



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Top Denial (835) Rejections

- Incorrect coding for diagnosis type
- LCD/NCD Various Errors
- The information furnished does not substantiate the need for this level of service
- Lack of specificity
- M81_Not coded to the highest
- Not specific based on RT or LT Modifier

Challenges
Issues



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How did we resolve them?

- Webinars
- Outreach to the provider community
- Established benchmarks for monitoring and early detection of issues
- Prompt communication to payers when issues were detected.
- Implemented escalation points of contact with external Trading Partners



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Metrics and Benchmarks

ICD-10 pre and post benchmarks

Overall Clearinghouses have not seen a substantial increase in call volume or cases related to ICD-10 above forecast.

- Total average claim volume from workgroup members:
 - October: 203,364,944
 - November: 220,254,548
- There is little to no variance in numbers set by benchmarks, pre-ICD-10 to post-ICD-10.
- Initially post-ICD-10 claim volume was less than 10%, however the claim volumes were steadily increasing each day, eventually surpassing ICD-9 coded claims.
- 62% of all claims received were coded for ICD-10 as of mid October
- Front end rejections from payers were minimal; both clearinghouse and payer rejection rates are within the baseline average.
- The vast majority (high 90%) of providers are coding claims correctly with ICD-10 codes for dates of service or discharge on and after 10/1.
- CE members have processed millions of claims with minimal ICD-10 issues.
- ICD-10 coded claims have certainly crossed the adjudication path with no major issues reported

Metrics Table

| Metrics | October | November |
|-----------------------------------|-----------------|----------------------|
| Claim Volume | 203,364,944 | 220,254,548 |
| % ICD-10 Claims Received | 62 | 88 |
| % of ICD Rejections 999/277 level | 1.5 | 1.1 |
| % ICD Denial Rate | 2.8 | 2.2 |
| Payer Reimbursement trending | Up | Down |
| % Unspecified codes | Slight increase | Starting to decrease |

- As of December the % of ICD-10 claims received has surpassed 93%
- Denial rates ranged from insignificant changes to less than baseline average.



Recommendations for continued success

Recommendations

- Qualifiers and codes must match. Ensure correct codes are used for the appropriate qualifier.
- CMS has discontinued all ICD-9 LCDs and NCDs effective 9/30/15. ICD-10 LCDs and NCDs are active on 10/01/15 and will apply to ICD-10 submitted claims.
- ICD-10 codes must be submitted with the required number of digits.
- Clearinghouses will continue to monitor inbound as well as outbound claims, payer rejections and 835 reimbursements
- Early identification of any issue is critical to minimize a negative impact to business so monitoring is key and essential to success, at all levels!



Provider Benchmark Metrics

- Know your business pre-ICD-10 so comparisons can be made for claims, rejections and reimbursements - a variance in numbers will lead to early identification.
- ICD-10 Provider Benchmark Metrics
 - Front End Rejection Error Rates
 - % of 277 CA front end rejections by status code /measured over unit of time (usually 2 week intervals)
 - Revenue Payment Cycle Variance Metrics
 - Average time (days) from claims submission to payment
 - Denial Rate Variance Metrics (Payer/Provider Benchmark)
 - \$ amount submitted on claim/ \$ Denied
 - % of ASCX12 835 payment denials by type of denial code (CARC/RARC)



Payer Benchmark Metrics

- Know your business pre-ICD-10 so comparisons can be made for claims, rejections and reimbursements - a variance in numbers will lead to early identification.
- ICD-10 Payer Benchmark Metrics
 - Standard Operating Metrics
 - Claims Auto Adjudication Rate
 - Percent of total claim for a defined period of time that are adjudicated without manual intervention.
 - Claims Accuracy or Rework – Percentage of claims not adjudicating correctly and resulting in rework due to an ICD-10 impact.
 - Claim Adjudication Cycle Time – Average days to adjudicate the claim. This metric could be presented by claim or provider type.
 - Suspended or Pended Claim Rates - The count and/or percentage of suspended claims by provider type and claim type



Summary - Lessons learned

When the industry works together with the right approach and do things the right way we are in a good place.

Early preparation and educating clients was key

- In summary the good news is, there's nothing but 'green' to report. Claims are moving, payers are accepting, and rejections are very low in general and in line with our everyday metrics created before ICD-10.
- Collaboration pays off.
- KPI's are running lower than before ICD-10.
- Industry gained new visibility into how the AR works.
- Revenue Cycle systems were improved.
- End to End testing was important. Can be improved.
- Promote X12 best practice to appropriately reject claims in a provider actionable manner via clear claim status messaging (277CA) versus a 999 acknowledgement batch file rejection.
- The 999 file acknowledgement transaction should only be used to report X12 syntax or TR3 HIPAA errors.





For More Information on the Cooperative Exchange:

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For More Information on ICD-10 Critical Metrics:

Visit WEDI website at [WEDI ICD-10 Critical Metrics White Paper Reference](#)

Or just use www.wedi.org Knowledge Center to access the WEDI ICD-10 Critical Metrics White Paper