

RETINA TIMES

The Official Publication of the American Society of Retina Specialists

Fall 2015
Issue 61

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Transitioning to ICD-10: Will the Disruption Be Worth It?

In 1997, Harvard Business School professor Clayton Christiansen coined the term *disruptive technology* in his best-selling book, *The Innovator's Dilemma*. There is a period of chaos after an organization implements new technology—or a new coding system such as ICD-10.

Retina Times talked with 3 thought leaders about implementing ICD-10 in retina practice, the integration with electronic health records (EHR)—and whether the disruption of the change to ICD-10 will ultimately be worth it.

Panelists



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Jonathan Feistmann: We all feel the success or failure of an organization's transition to ICD-10 depends heavily on EHR preparedness. What should organizations understand about what an EHR can—and cannot—do to transition a practice from ICD-9 to ICD-10?

Dan Montzka: Assuming the physician is not an expert—and doesn't really want to become an expert—in ICD-10, I think the EHR systems can do a lot for the doctor and the clinic. One thing would be an automatic conversion of your existing problem list to ICD-10 full formatted codes, and that's a big thing.

Because you're not doing that conversion as a manual process, that will save a lot of clinic time. And with new patients, I think that whatever system your practice uses to generate those codes, the coding should be done in the exam room before you complete that encounter.

Jonathan Feistmann: Why do you say that?

Dan Montzka: Because you don't want the billing department having to bounce things back and forth. If the clinical information is incomplete, you'd like to know it before you sign off on that encounter. It's going to be very inefficient for clinics if the billing department needs more information from the clinician.

Jonathan Feistmann: That's a pearl that is even truer with ICD-10. So now we put the codes in as you mentioned. How does the EHR need to interface with the electronic

practice management (EPM) system to make sure the codes are transmitted correctly?

What are the necessary elements of the EPM to make sure it can submit the codes properly? Where do you see potential breakdowns? What do we all need to make sure happens and what do we all need to look out for?

'You don't want the billing department having to bounce things back and forth. If the clinical information is incomplete, you'd like to know it before you sign off on that encounter.'

—Dan Montzka, MD

Dan Montzka: Typically, that submission process is done using a standard, the HL7. If you're using a separate EHR vendor from the EPM vendor, it would be done with an HL7. Those systems are in place in ICD-9, so I see those things functioning pretty similarly.

One of the biggest changes is the laterality that needs to be selected in ICD-10. And that's why

I think it's important that the EHR lets you know, as a clinician, that there's a deficiency before you close the encounter and makes it simple—so it's not a long, drawn-out process to search for the proper ICD-10 code.

Jonathan Feistmann: How can EHR help physicians with laterality?

Dan Montzka: A lot of the more advanced systems were already handling laterality under ICD-9, and I think the laterality can be obtained during the encounter. If you have an intelligent EHR system, it can pick up the laterality as you're documenting the clinical encounter and transmit that through to your impression and then into the ICD-10 coding. You don't want laterality to have to be an extra step; an intelligent EHR system will be able to pick that up during your exam.

Jonathan Feistmann: Joy, speaking of laterality and the human element, a lot of people are doing the crosswalk from ICD-9 to ICD-10, but for many codes, there is not a 1:1 crosswalk because there are so many more codes in ICD-10. How important is the human element for physicians, billers, and coding specialists in using ICD-10 correctly? What do we need to keep in mind?

Joy Woodke: The human element is very important. The crosswalk that many systems do where they download "this ICD-9 code equals this ICD-10 code" is a great start, but when there's a 1:1 crosswalk, it mostly links to the unspecified codes.

So if there was indeed laterality, it's still going to only code it to the "9"—"unspecified"—eye. That's where we need that end-user to look at the chart, let's say on an established patient, to know if this was in the right eye or the left eye and update those codes to have the laterality as appropriate.

There are also other codes that will not crosswalk. For example, the diabetic macular edema code will not crosswalk to an ICD-10 code because it doesn't know the retinopathy and the type of diabetes—so those need to be handled by the end-user and updated appropriately.

Another example is the trauma code. If we have a patient with a corneal laceration in her problem list, we have to update whether this is the initial, subsequent, or a sequela type of trauma. So, the crosswalk is a nice starting point for a problem list to be updated to ICD-10, but then we need to look at the problem lists and update them appropriately.

Jonathan Feistmann: Now that we're a few weeks into using ICD-10, what do you recommend that practices do to make the transition easier?

'The human element is very important. The crosswalk that many systems do ... is a great start, but when there's a 1:1 crosswalk, it mostly links to the unspecified codes.'

—Joy Woodke, COE, OCS

Joy Woodke: I recommend that practices start what's called a *preload workflow*, to look at charts scheduled on an upcoming day. Look at those charts before you see the patient and update the problem list to have the correct laterality and the correct trauma code, A (initial encounter), D (subsequent), or S (sequela) as appropriate. Make sure macular edema codes have the correct ICD-10 code in the problem list; and update the problem list to be specific.

Dan mentioned a very good point—making sure our charts are documenting what's in the right eye and what's in the left eye. If we're not doing that already, we definitely should be. But as we transition to ICD-10, making sure our chart documentation has that is essential so we know which code to choose. If the laterality is in our chart, then we can preload it.

As we look at those libraries and we're updating ICD-10 codes, is there a way we know and we can flag, for example, other information we need—whether it's more-specific characters or whether we need additional characters for a trauma code? And how are we letting the end-user know if there are notes for Exclude1 (mutually exclusive codes) or Exclude2 (codes that can be billed together)?

Internally, how can we update our system for the key elements that could lead to denials—if we're billing 2 codes, for example, that are mutually exclusive?

Jonathan Feistmann: Yes, that's another key question: how are these factors going to affect our claims? And what are the denials we're going to start seeing?

Joy Woodke: The goal would be to avoid all those denials. I think we can anticipate what some of them could be and start working toward eliminating those denials.

Jonathan Feistmann: Sure. Jeff, let's turn to you. The conversion from ICD-9 to ICD-10 has involved considerable cost and effort.

Jeff Brockette: Yes, and I agree with Dan and Joy about the use of the EHR and the documentation—I think that's a critical component. Dan is right about what EHR can do, but I think a lot of practices are still relying on internal coders who are doing work for the provider at the end of the day.

It is understood that ultimately, the doctor is responsible for the coding and providing the information for all of the documentation and compliance components. The conversion to ICD-10 is an opportunity to retrain and become more compliant, just like when we went to EHR—it was a complete shift in the process of the workflow for the providers.

An advantage for small practices is that they may have the opportunity to get all of their staff and physicians in a room at the same time and train for the transition together. Large practices will not be able to do this and will have to initiate training differently, ultimately relying on their systems to make the transition work.

'Ultimately, the doctor is coding and providing the information for all of the documentation and compliance components.'

—Jefferey T. Brockette

That is where larger practices may have an advantage. They should have the capital infrastructure to do system upgrades on time and/or have resources allocated for the training and managing of those system upgrades. There will be a difference between small and large practices' conversion to ICD-10 in both cost and effort. But practices of all sizes should be prepared—every practice's cash flow will depend on a smooth transition.

Jonathan Feistmann: That's a good point, especially about retraining. As Dan mentioned, ICD-10 is forcing us to do what we should have been doing all along—seeing the patient, then documenting as accurately and as quickly as possible and not risking inaccurate claims by leaving our staff to chase around for the details. With ICD-10, that's not even possible anymore. The coding needs to be done by the physician, right then and there.

Jeff Brockette: ICD-10 flushes out problems in the process flow. If we weren't documenting it correctly in ICD-9, goodness knows we're not doing it right in ICD-10. If the documentation trail did not follow through to the claim correctly then, it's certainly not going to happen now in ICD-10. The transition to ICD-10 presents the opportunity to correct issues like this.

Jonathan Feistmann: What are the issues for these first few weeks of going live in ICD-10?

'ICD-10 flushes out problems in the process flow. If we weren't documenting it correctly in ICD-9, goodness knows we're not doing it right in ICD-10 ...'

—Jeff Brockette

Jeff Brockette: Earlier, Joy mentioned the initial denial management. I think the issue is holding those insurance companies accountable, addressing the denials as quickly as possible, and identifying the trends of these denials—understanding what we can change, and hitting it head on.

We can't wait 45 days to determine, "Oh, we've got some accounts receivable (AR) sitting out there that we need to figure out." Some practices still do manage AR that way, and I think it's critical that they not wait until that traditional post-30-day timeframe before they start seeing what's happening.

Dan Montzka: I agree. This go-live period is a potentially disruptive event for clinic workflow in terms of how many extra clicks it

is going to take us to complete these encounters and get it right, as well as the billing systems and eventually cash flow. And I agree that we need to stay on top of all this; we need to be on our toes the first few weeks of ICD-10 from the clinical side, the billing side and collection, so it really doesn't affect our cash flow as significantly as it could for some clinics.

Jonathan Feistmann: As Jeff mentioned, it's an interesting switch to EHR and now ICD-10. With EHR, there was no change or worry about cash flow—the change was more about the time required. But now I think people aren't going to worry about the time as much as they are about maintaining the cash flow and making sure they do everything accurately, and I think that's absolutely critical.

Joy Woodke: I think there are going to be different types of delays in payment. Insurance companies are also going to be challenged with these changes under ICD-10. Their computer systems might not be processing claims quickly. They might also be denying claims inaccurately. So it's most important that we know in our offices what is a true denial and what is a mistaken denial.

The insurance company might say, "This is an inappropriate ICD-10 code," when in fact, it's correct. So if we have the knowledge, we're going to be able to appeal the claim correctly. But the most important part is when we get those denials, how are we going to appeal them? Do we have the knowledge to identify the error quickly? Is it our error or the insurance company's?

I think a lot of times, the insurance companies take this as an opportunity to hold claims, because they're also trying to update their processes and computer systems. We should be prepared for the fact that the insurance company may take additional weeks to process clean claims.

There will be multiple reasons why we might have delays in payment. So the most important takeaway is that we have to address the denials quickly, and we have to know how to appeal them.

Jeff Brockette: I'm also concerned that this grace period from the Centers for Medicare & Medicaid Services (CMS) might be doing us a disservice. I think it's important for us to note that it's not as cut and dried as we may think. People might get a listserv e-mail blast and say, "Oh good, we've got a grace period."

To Joy's point, if people think, "I'm not going to worry about these denials because we have a grace period and something's going to fix itself," that doesn't apply to the insurance company playing its games; it applies only to the government payers. And it's a grace period, which is not necessarily saying that we don't have to submit claims with the correct valid code. Our goal should have been to get it correct the first time October 1.

Jonathan Feistmann: Are you concerned about any specific retina codes that you think are going to be an issue?

Dan Montzka: I think the diabetes codes are going to be somewhat problematic, just because there are so many. We found it was better to allow the clinician to specify the severity of the retinopathy and the presence or absence of DME in separate problem-list items. This gives the clinician more flexibility in documentation—for instance, central vs noncentral DME can be easily documented and tracked in an analytics package. We then created an algorithm so the software can determine the indicated ICD-10 code.

The algorithm we designed also provided us an automatic translation from the existing ICD-9 problem list into an ICD-10-based problem list. If this conversion process is not automatic it will place a significant workflow burden on clinics as they manually update patient records to ICD-10.

Jonathan Feistmann: So, going back to laterality, wet and dry AMD as well as diabetes don't have any laterality in ICD-10, while other diagnoses do. Do you expect any issues with bilateral injections, and how will that affect claims?

'I think the diabetes codes are going to be somewhat problematic, just because there are so many.'

—Dan Montzka, MD

Joy Woodke: No matter what, our chart documentation should say, "Patient has wet macular degeneration in the right eye and we're injecting the right eye today." As long as we're sending the correct wet-AMD code with the injection code, we shouldn't have a denial.

Even if that injection was bilateral and it was the correct wet-AMD code, we shouldn't have an issue. What *would* be an issue is if the patient was wet in one eye and dry in the other and then we're not having the proper linkage. In ICD-10, people need to understand the importance of proper linking of diagnosis codes with CPT codes.

But what I see as a challenge with the transition is the impact on claims involving codes with laterality. For example, retinal detachment single break, H33.012, in the left eye, and then the patient also has retinal detachment in the other eye but we're operating on the right eye; and if we're linking a left-eye diagnosis with a right-eye surgery, that's where I could see having challenges. Again, diagnosis link is essential.

Jonathan Feistmann: So, laterality is critical, and it's something that's not in our ICD-9 coding lexicon. I can definitely see that as adding to another possible "common" mistake.

Joy Woodke: Just like a scrub.

Jonathan Feistmann: Yes.

'In ICD-10, people need to understand the importance of proper linking of diagnosis codes with CPT codes.'

—Joy Woodke, COE, OCS

Joy Woodke: Yes, so our charge-entry staff, our billers and coders who send out the claims, need to train their eyes to look for codes that have laterality and make sure they're linked appropriately with the CPT codes. The injections could pose a challenge, of course, if we were billing the incorrect diabetes code—for example, linking a diabetes code without macular edema, which ends in a 9 instead of a 1 indicating with macular edema.

And let's say the patient didn't have macular edema in one eye but did in the other eye. Again, as in the wet- and dry-AMD example, we need the appropriate diagnosis linked to that injection. The billers should review claims and confirm the diagnosis link is correct.

Jonathan Feistmann: Dan, how might the unique elements of the ICD-10 affect the retina specialist in the long run?

Dan Montzka: In the future, I think more EHR systems will move to a higher degree of specificity and granularity in how they document clinical elements. Systems moving in that direction are well suited for the future; because they were already documenting with a high degree of specificity and granularity, the movement to ICD-10 is not a big deal because those data elements are already there and can be converted. It doesn't require a manual process at that point.

I'm not a big fan of ICD-10, but if something good is going to come out of this, I think it's that systems are going to move more toward higher specificity in the documentation and higher granularity in how clinical information is stored and referenced.

Jonathan Feistmann: So, why are you not a big fan of ICD-10, besides the obvious?

Dan Montzka: I think it's unnecessary; if you want to add specificity, they could have done it in a much more clinically useful way. ICD-10 is a lot of work for a minimal amount of benefit in my opinion. I think it could have been designed much better to handle clinically relevant specificity. To me, there's very little clinical advantage to what we have gained compared with the tremendous expense of implementation.

Jonathan Feistmann: So, what clinical advantage do you see in the long run after all this tedious work?

Dan Montzka: Honestly, it's almost like saying a stopped clock is right twice a day—that's how I see ICD-10. It's almost inadvertent if there is an advantage, and I think innovative EHR vendors and clinicians will always find a way to overcome obstacles and take excellent care of our patients. That's the bottom line—what we all want to focus on—and I see ICD-10 as a distraction to doing that. But we will find ways to adapt and care for our patients, and I think in that process, we may find some benefit.

Jonathan Feistmann: Jeff, what do you think?

Jeff Brockett: I think Dan's point about clinical relevance is excellent because we're already providing laterality; we're already documenting. If ICD-10 was designed to have better clinical outcomes, I don't think this is the key. But as I said earlier, ICD-10 is forcing people who might have been holding off to move forward in technology.

In our practice, we hadn't upgraded our EHR since 2008 because we didn't have to, and we just went through a big EHR upgrade. That, in

itself, has a lot of benefits for everything from documentation to record keeping to workflow, and so, I think that's a sideline benefit that will help—plus all the training that goes alongside it.

Jonathan Feistmann: Jeff, how have you prepared your practice for ICD-10, and what troubleshooting are you doing for these first few weeks?

Jeff Brockett: Once we got through the IT component of our EHR upgrade, we focused on awareness and training; we started at high-level meetings with all the general staff and worked our way into specific offices and job functions such as business office and technician. We are ensuring resources are available for all staff and also at the physician level. Our centralized billing area will be the final checkpoint before claims are submitted.

Jonathan Feistmann: Joy, what are your thoughts about why we're switching to ICD-10, how this may help us, and what we may get out of this in the long and short term?

Joy Woodke: Why are we switching? Bottom line, it's because the rest of the world has gone to ICD-10 and we're behind the times, right? That's what we've heard many times. There's not much we can do about it.

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—Dan Montzka, MD

So I look for the silver lining from a coder and biller perspective when we're talking about things like ophthalmoscopy, which under ICD-9 was bundled with retinal procedures. There are certain examples where we're treating one eye, let's say the right eye, but in the left eye it was medically necessary today to do an ophthalmoscopy. In that case, we billed and unbundled the code with a 59 modifier under ICD-9.

Here's an instance where I think ICD-10 is helpful, because if it's a code with laterality, I'm going to attach and link the code to the other

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