The Impact of ICD-10 Implementation on Denials

The much anticipated after effects of ICD-10 implementation on denials have had much less force than originally expected. ICD-10 held the spotlight in healthcare news for the past two years. Thanks to much preparation, the resulting denial impact has been limited. However, before the rollout of ICD-10, CMS stated it would give a year's grace period in reimbursement of claims so long as the claims were submitted in the correct family of codes.

What seems to be bigger issues for hospitals are lower reimbursement of claims and a slowdown of processing ICD-10 claims for payment. Clinical documentation that is unclear or non-specific is having the greatest impact on coding, resulting in lower reimbursements. Continued coding education and ensuring clinical documentation is detailed and accurate, are steps all providers should continue to take.

To remain vigilant in tracking your data and keeping an eye on your payers, continue to refer to the CMS ICD-10 Toolkit.

Reference link:

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10NextStepsToolkit20160226.pdf

TYPES OF SERVICE LEVEL 1	DENIED RATE (10.01.2015-3.31.2016)	DENIED RATE (10.01.2014-3.31.2015)
TESTS	18.2%	17.8%
EXCEPTIONS/UNCLASSIFIED	15.9%	16.6%
DURABLE MEDICAL EQUIPMENT	15.6%	18.4%
OTHER	14.5	16.7%
PROCEDURES	12.5%	13.9%
IMAGING	11.3%	11.7%
EVALUATION AND MANAGEMENT	10.8%	11.4%

RemitData recently published the data in this table comparing denials rates on some services for the same time period in 2015, prior to ICD-10 and post ICD-10 which indicates a reduction in denials.

The CMS ICD-10 Toolkit contains data for both physician providers and facilities. Some points to keep in mind when while assessing your ICD-10 progress:

Use key performance indicators that are important to your practice or hospital. By now, you may have established or began to establish a baseline for each KPI. Some KPIs you may track are:

- Days to final bill
- Days to payments
- Claim acceptance rate
- Reimbursement rate
- Volume of coder questions
- Use of unspecified codes
- Medical necessity pass rate
- Claim denial rate

If you can track at the payer level, it is even better. Keeping a scorecard and sharing the score with the payer should help keep lines of communication open and your claims processing more efficiently.

Have you developed a Feedback System? Listen to your staff. Besides keeping an eye on the KPIs, your staff is at the frontline and can provide valuable insight and possible suggestions for improvement.

Many of Anthelio clients say the jury is still out. Data analysis is key, including scrutinizing DRGs, comparing reimbursements of ICD-10 claims versus ICD-9, and looking at the impact of ICD-10 after October 1, 2016.

Share your post ICD-10 implementation experiences with us at Anthelio.Communication@antheliohealth.com.