Chiropractic Coding & Compliance Alert

ICD 10 Update: ICD-10 Implementation: Where Does Your Practice Stack Up?

Take these 4 steps to ensure you're on the right track.

You know that ICD-10 implementation in October 2015 will completely change the way you code diagnoses. But have you thought about how it might affect your staff's productivity? With some experts predicting a 50 to 70 percent drop in coder productivity (at least initially); it's time to start thinking of ways to maximize efficiencies when the transition begins. Keeping four key areas in mind can help you get started.

Step 1: Rework Your Approach to Documentation

Old habits die hard, as the old adage says, even in the coding world. The single biggest challenge in the transition to ICD-10 may come not from the coding perspective as much as from providing the requisite documentation.

Providers might be able to have less than stellar documentation for ICD-9 coding, but that won't be the case with ICD-10. Code descriptions will be much more detailed, so start working with your providers now to accurately document procedures and services so as to match the future code descriptions. You need not wait until the new codes are in place to practice better documentation; start adapting to the new documentation style now and it will feel like the transition battle is halfway won.

Step 2: Focus on Your Top Codes

The sheer numbers of codes in ICD-10 can be enough to worry any coder or provider. The diagnosis code hierarchy has neurological conditions on the top, followed by structural, functional and soft tissue pathologies.

For example, sciatica (724.3) will carry more weight than soft tissue problems like spasm (728.85) or myalgia (729.1) when establishing medical necessity. As per Medicare, medically necessary chiropractic services which one gets paid for are confined to active/corrective manual manipulations of the spine to correct subluxations.

Plus: You must use the acute treatment (AT) modifier to justify your claims. When further improvement cannot be demonstrated, the services are thought of as maintenance therapy, which you would not be paid for. Your best preparation tactic is to determine a relatively short list of ICD-9 codes which you use most often now, and learn what they'll change to under ICD-10.

"Most systems will let you run a report of your most frequently used codes. This is a great way to determine which codes you use," says **Elizabeth Earhart, CPC**, with Godshall Chiropractic in Millersville, PA. "I also review the code set list for Medicare and make sure I am paying attention to the hierarchy of codes. Coding to the highest specificity now will make it easier for the transition."

Here are some examples:

- ICD-9 codes requiring short term chiropractic care (6-12 treatments) such as 721 for spondylosis and 723-724 for back pain
- Frequently used codes referring to moderate term care (12-24 treatments) include 353 for root lesions, 722.9 for unspecified disc disorders, and 724 for stenosis, and 846-847 for sprains.
- The usual codes for long term care (more than 24 treatments) represented by 722 for degenerated or displaced discs.

Good news: CMS is now providing a list of ICD-10 codes that are medically necessary in conjunction with appropriate CPT® codes in the Local Coverage Determination (LCD) data available.

Next steps: Use the general equivalence mappings (GEMs) written by the National Center for Health Statistics (NCHS) as the starting point for cross walking the ICD-9 codes to their ICD-10 equivalents. However, remember that GEMs provide only approximations and that other; more specific diagnoses might apply in a specific situation.

"I personally do not like using GEMs because it does not always recognize the best codes or gives you several to choose from," admits Earhart. "I actually created my own cheat sheet linking the codes that apply using the list of codes we use the most."

That means use the information you collect to create your very own crosswalk knowledgebase for the most frequently used codes in your practice.

"Practices should closely examine their high volume services relative to changes in procedure coding," says **Duane C. Abbey, PhD**, president of Abbey and Abbey Consultants Inc., in Ames, IA. "Computer reports can identify high volume areas and then the coding changes can be assessed along with possible increased documentation requirements. By focusing on high volume, and generally high dollar, areas both coding and the supporting documentation can be addressed in a focused manner through increased training."

Reality check: You will need to prioritize by determining the most common codes for your practice. Your coding team might need to divide into smaller groups to focus time on specific diagnosis or procedures, depending on how extensive your list it.

Step 3: Create a Strategy to Reduce Denials

Some people might say that collecting from Medicare for chiropractic services is next to impossible. However, this mindset seems far from reality, considering that Medicare reportedly paid 47 percent of the claims inappropriately amounting to extra unnecessary payment of $178 million out of total payments of $ 466 million.

The OIG could identify many errors warranting denial, including miscoding, poor documentation, and maintenance therapy being billed as chiropractic manipulative correction (CMT). Overpayments included services claims later determined by OIG as "maintenance therapy ($ 157 million), miscoded ($ 11 million), or undocumented ($ 46 million)," according to an OIG report in May 2009 titled "Inappropriate Medicare payments for chiropractic services" (http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf).This calls for a little introspection.

Section 2251 of the Medicare Carriers Manual (MCM) states, "Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, listing examples of manual manipulation as spine or spinal adjustment by manual means; spine or spinal manipulation; manual adjustment; and vertebral manipulation or adjustment." In addition, Medicare and most private insurers require a diagnosis of subluxation of the spine (for example, 739.1) to demonstrate medical necessity for CMT billing.

"When using the CMT codes for Medicare, remember to support that code with a symptom or condition. 739.2 followed by 724.1 (Pain in thoracic spine) is more specific than 728.85 (Spasm of muscle)," advises Earhart.

With the amount of money that has been at put at stake in the past, CMS now will be really stringent when reviewing these claims. Speaking about the strategy to reduce denials, Earhart has a solution: "Remember the SOAP formula for documentation. As long as you have a complete note and demonstrate progress, your chance of denial lessens."

You will need to develop your own way of documentation so that you do not fall into this vicious circle of poor documentation and denials.

Step 4: Analyze Your Inefficiencies

It is said that a chain is only as strong as its weakest link. Now is the perfect time for facilities to analyze inefficiencies that thwart current performance levels and strengthen your billing and reimbursement process chain. Abbey

recommends that you ask questions such as:

- What are the top reasons you receive denials?
- Does your practice have a strategy to reduce denials?
- How do you address medical necessity issues?
- How frequently must physicians be queried for additional information?
- Is documentation provided in a timely fashion?

Final take-away: Even the smallest inefficiencies can multiply, having an exponential effect on productivity slowdown. The more you can begin addressing areas now, the sooner your productivity levels will return to normal under ICD-10.