Six ICD-10 Questions for Your Medical Claims Clearinghouse

A key partner in the ICD-10 transition is your claims clearinghouse. Here are six key questions to ask now to be sure you are both ready.

Source: Physicians Practice

It's September, and you've been busy since February preparing for ICD-10. No? Well, fortunately you still have 12 months to get ready. One key partner in your preparations should be your medical claims clearinghouse.

One of the things I learned from the HIPAA 5010 transition was that it hurt cash flow in way too many practices. I had the chance to observe two practices that had the same practice management system, the same payers, but different clearinghouses. One practice was a month down on cash flow well into the spring; the other had no cash flow disruption at all.

A very few clearinghouses made the 5010 transition seamless for practices; accepting both 4010- and 5010-formatted claims and then converting them, as necessary, on a payer-by-payer basis. I never appreciated the value of a reliable clearinghouse partner until the 5010 transition.

So how does that lesson apply to the ICD-10 transition? As with 5010, your practice's cash flow will be at risk during the ICD-10 transition. Here are six questions to ask your clearinghouse as you prepare your practice for ICD-10.

1. Our practice suffered a disruption of cash flow during the 5010 transition. What will you do differently with ICD-10 to prevent a repeat performance?
   (This is an optional question for practices that suffered during the 5010 transition. If you do not like the answer you get, consider moving to a clearinghouse whose 5010 performance was stronger.)

2. Would you please run a report of claims rejections and denials by ICD-9 code?
   (And while you're at it, please provide guidance on how to prevent these errors.)

3. Would you run a similar report by payer?
   (Such a report will give you a good basis for meeting with your key payers and discussing their ICD-10 conversion plans.)

4. Please run a report that identifies the "generic" codes each provider uses regularly.
   (Generic ICD-9 codes (like 250.00 for Type II diabetes) are most likely to be denied by payers going forward. These codes should be your first priority as you commence ICD-9 to ICD-10 mapping.)

5. Could you share advice on mapping my superbill from ICD-9 to ICD-10?
   (Coding remains each provider's responsibility. However, your clearinghouse may be helpful in this critical exercise.)

6. Could you share the progress of your discussions with my practice management vendor and my payers? When can we start sending test claims?
   (Mapping from ICD-9 to ICD-10 is not an exact code-for-code proposition. Prudent practices will map — test — refine — test — refine their coding well before they submit their first real ICD-10 claim on Oct. 1, 2014.)

Post ICD-10 performance evaluation

TK Software of Carmel, Ind., is one clearinghouse whose clients were unaffected by the 5010 transition. TK Software's managing partner, Matt Behringer, shared their post-ICD-10 plans: "A post ICD-10 performance evaluation is critical," Behringer says. "Your clearinghouse should be able to create reports that show encounters, dollars billed, dollars rejected, and/or denied [claims] per day for each provider, pre- and post-ICD-10."

I agree. Ongoing cash flow in an ICD-10 world will require diligence and corrective education in the days and months following Oct. 1, 2014. A reliable clearinghouse partner helps, but it remains incumbent upon practices to begin their ICD-10 preparations now.

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