AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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Addressing Issues Post ICD-10 Go Live

- **Bottlenecks in Workflow**
    a. Prior Authorizations
        i. Evaluate documentation for trends in missing data
            1. Discuss with physicians
        ii. Ask payer for list of approved codes
            1. Double check code submitted
            2. Ask for copy of ICD-10 guidelines they are using (including publisher, product name and version) to assess accuracy of the information
            3. Nonstandard payer-specific coding edits should be supported by applicable information
            4. Cite ASPS coding guidelines
        iii. Request peer review
        iv. Follow up!
    b. Coding taking too long
        i. Develop crosswalks for most-reported dx codes
            1. Plasticode. Developed by ASPS – crosswalk of ICD-9 to ICD-10 codes.
            2. Software. ICD10data.com is a free website to search for ICD-10 codes.
    c. Missing Clinical Documentation
        i. Evaluate for trends in required information
            1. Discuss with physicians
- **Can't submit claims coded in ICD-10**
    a. Check dates of service on claim.
        i. Dates prior to October 1 must be coded in ICD-9
            1. Claims can't have both ICD-9 and ICD-10 codes on the same claim
            - For hospitalizations ending after October 1, code entire claim in ICD-10
    b. Some Medicaid programs, including California, Louisiana, Maryland and Montana will continue using ICD-9 as a "temporary" workaround because they can't calculate payments under ICD-10, but claims should still be submitted using ICD-10
    c. Verify work comp and other liability claims requirements
        i. See State readiness document on ASPS ICD-10 website)
    d. Verify the practice's billing software is able to accept/transmit ICD-10 codes
    e. Investigate alternative claims submission process
        i. Free billing software provided by most Medicare Administrative Contractors
            1. See MAC website for more information
        ii. Check with Billing Service Companies for assistance with submitting commercial claims
    f. Consider paper claims

i. Direct data entry may be used for Part A claims, but requires connectivity to an external company to establish the connection.

- **Claim Denied**
    a. Monitor and identify patterns in denials
        i. Common Remittance Advice codes
            1. N755 "missing/incomplete/invalid ICD Indicator on claim"
                a. If using paper claims, check the ICD Ind., in box 21. This field was added for differentiating between ICD-9 and ICD-10-CM diagnosis codes. The indicator options are 9 for ICD-9 or 0 for ICD-10.
                b) For electronic claims, check loop 2300, segment HI01-1. The indicator options for the ANSI are BK for ICD-9 and ABK for ICD-10.
            2. N742 "this claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015."
        ii. Check use of RT and LT modifier match with any diagnosis codes that specify right or left
        iii. Verify code reported is valid ICD-10 code
            1. See list of all valid codes on ASPS website
        iv. Track trends by payer & address
        v. Ask payer for list of approved codes
            1. Double check code submitted
            2. Ask for copy of ICD-10 guidelines they are using (including publisher, product name and version) to assess accuracy of the information
            3. Nonstandard payer-specific coding edits should be supported by applicable information
            4. Cite ASPS coding guidelines
        vi. Request peer review
        vii. Follow up at 30 days
    b. Understand the Grace Period
        i. Medicare versus Commercial payer
            1. "Family" of codes
                a. Medicare will not require 100% specificity. Will pay for codes in same "family" unless Local Coverage Policy excludes some/all codes reported
                b. Most commercial payers will expect 100% specificity
        ii. Review valid ICD-10 codes – review list on ASPS site
    c. Resubmissions/Appeals
        i. Follow up at 30 days
- **Evaluate availability of advanced payments**
    a. Medicare versus commercial payer
    b. Line of credit w/bank

- **Optimize Patient Selection**
    a. Cosmetic (cash) versus Reconstructive (insurance) during transition