Leveraging comparative analytics, Payers can identify and resolve ICD-10 related issues

After years of delays, the October 1 ICD-10 conversion date has come and gone. But if you think the hard work associated with the ICD-10 transition is over, think again. As payers begin processing post-Oct. 1 claims, providers are going to need more guidance from payers than ever before.

As providers finish addressing their own initial system and productivity issues, they now brace for payment issues that may affect their bottom line. Despite the ICD-10 grace period, provider anxiety associated with increased denials and reimbursement delays is running high.

Many are taking action to ensure their cash flow is secure. RevCycleIntelligence reports, 67 percent of over 300 responding physicians have taken out a line of credit to prepare for possible ICD-10 based payment delays. Approximately 93 percent expect payment delays to continue following the end of the ICD-10 grace period, according to a poll conducted by SERMO.

On the other end of the spectrum, payers will likely begin to feel provider pain points with a rise in administrative costs tied to increased denials and appeals. For example, providers may try to avoid the possibility of claim denials due to miss-matched codes by requesting their prior authorizations and referrals be reissued for services carried over during the transition period.

What can payers do to help guide providers through the ICD-10 transition while keeping administrative costs at bay?

Implement a Denials Resolution Plan

Despite the ICD-10 noise, provider advocates can use comparative analytics solutions to pull reports in a matter of minutes and help their providers monitor the impact of ICD-10 on their revenue and days in account receivables.

Leveraging comparative data, payers can help providers establish benchmarks and the baseline standards needed to create a denial management plan. These baselines must evaluate claim denial rates and accounts receivables data based on both pre- and post-ICD-10 data.
Armed with this information, payers can then inform providers as to where they are experiencing the greatest impact and why. This collaborative approach will allow them to create a plan that resolves the biggest issues with the greatest impact.

- Is it taking the provider longer to get paid as the result of longer claims processing times?
- Is the provider experiencing a spike in claims denial, eligibility denials, and other areas?
- Is the provider’s denial rate in-line with peers?
- Is the provider experiencing new issues or are they in line with previous issues?

Comparative analytics can track denial trends to help determine whether the problem existed before ICD-10, after or both. Working together, payers can guide providers to identify problem areas and develop corrective actions – are claims being submitted with the correct code, is the front office staff billing properly?

**Comparative Data Can Help Strengthen Provider Relationships and Improve their Revenue Cycles**

Payers can use comparative data to guide their provider networks in a variety of ways, beyond simply leading them to implement a denial management resolution plan.

- Identify and track administrative cost reduction initiatives.
- Analyze allowed amount comparisons at national and state levels (by major procedure code grouping to strengthen contract negotiation discussions).
- Implement communication plans aimed at helping providers adjust to ICD-10, including weekly or monthly messages that address topics such as “top 3 issues payers see across all physicians in a particular specialty or certain area”. Establish highly targeted messages and educational campaigns by specialty that are driven off of key findings in the data. For example, in October 2015, the top 5 Most Common denials for Family Medicine were 99213, 36415, 99214, 99000 and 90471. Using this information, payers can develop a targeted campaign to all Family Medicine providers showing the highest denials in these areas and outline the major steps to reduce them.
- Because payers have the data and the influence to lead change in the healthcare industry, they should evaluate this data on a daily, weekly and monthly basis to intercept and communicate downward trends before they get out of control. As a payer sees improper use of a specific code by a large number of providers, they should inform those providers about the coding error and communicate the correct code. Keeping a close eye on what the data reveals can go a long way in preventing denials, eliminating unnecessary administrative costs, and minimizing negative impact on the provider’s bottom line.

Through the use of comparative data, payers can achieve more transparent and productive conversations with their provider networks to strengthen those relationships and prevent the same issues from reoccurring. By working together to identify these administrative challenges prospectively and transparently, all parties win.