

## Talk to Your Payers about Reimbursement Changes for ICD-10

For physician practices, you may think that your reimbursement will not be impacted by ICD-10, since the Current Procedural Terminology (CPT®) codes drive payment in the outpatient and office settings. While the diagnosis code reported on the claim is generally used to support medical necessity for why the procedure or service was performed, it is also used by payers to identify benefit coverage.

During the implementation of ICD-10, payers will be reviewing their medical policies and may make changes to their benefit coverage and reimbursement that will be triggered by the ICD-10 code. There has also been general talk that, due to the more granular data in ICD-10, some payers may decide to change their current acceptance of “unspecified” codes. For claims submitted with an “unspecified” code, payers may decide to pend the claim and request additional information, pay the claim at a lower rate, or deny the claim. Knowing in advance what your payers will do with their reimbursement policies will better prepare you for ICD-10.

The following are questions to ask your payers about their ICD-10 reimbursement:

- Will you be changing your benefit coverage based on diagnosis codes?
- How will you process “unspecified” codes?
- When will your updated policies be available for us to access?

For practices that bill Medicare, ask your local contractor the following questions:

- How will the Local Coverage Determination (LCD) or National Coverage Determination (NCD) criteria be impacted by ICD-10?
- What process will you use to notify practices of changes to the LCDs and NCDs due to ICD-10?

In addition to anticipating reimbursement changes, you should also monitor certain information related to claims processing and reimbursement, if you are not already doing so. Tracking certain data before the ICD-10 deadline will give you a baseline to compare to after the switch. The following are several data you may want to track:

- Number of pended claims for additional information related to diagnosis
- Number of denied claims related to diagnosis coding
- Average reimbursement for specific priority services performed
- Overall account receivables
- Number of other transactions (eligibility, prior authorization) that include diagnosis codes pended for additional information related to diagnosis
- Number of other transactions (eligibility, prior authorization) that include diagnosis codes denied related to diagnosis code
- Number of requests for additional information to support transactions (claims, prior authorization)

If you are unable to contact all of your payers about their reimbursement changes or track all of your claims for all of your payers, focus on the high volume and high dollar payers.

Be prepared before the October 1, 2015 deadline for possible changes in your payers’ reimbursement policies based on the changes in ICD-10.

**Visit the AMA’s website for more resources on ICD-10**  
[www.ama-assn.org/go/ICD-10](http://www.ama-assn.org/go/ICD-10)