ICD-10 codes are on all claims—and a valid ICD-10 code will be required on all claims—CMS has recognized that the move is bringing significant changes to providers and has implemented some audit flexibilities. According to guidance published on CMS' website, as long as a valid code from the right family has been used, it will not deny claims based solely on the specificity of the ICD-10 diagnosis code for the first 12 months of implementation.

Be Vigilant Right Now

Ford says this initial transition period is the most critical for O&P practices because they may have received a prescription from a physician before the October 1 change date that included ICD-9 codes, but the definitive device was not ready until the diagnosis code requirement switched to ICD-10.

> "The software system isn't going to look at what's going on with the patient and know the history, and know it will automatically lead to an ICD-10. Your administrative staff needs to be paying attention."
>
> —Mark Ford

"There's almost always a lag time in the O&P patient care process, and that lag time is where the problem is," he says.

The good news is that CMS has said it will allow offices that submitted ICD-9 codes after the October 1 cutoff to resubmit the claims and be reimbursed, Ford says. However, if an O&P office isn't paying attention, the number of claims that it will need to resubmit can build up and potentially affect the staff's time and the business' accounts receivable.

"I think the biggest risk for O&P practices is really in the first 90 to 120 days," Ford says. "If a third of your claims have incorrect diagnosis codes in a 60-day window, those claims will have to be resubmitted, which will then have a dramatic impact in slowing down the cash flow for your business. That's the biggest fear." O&P EDGE

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