3 EHR Must-Have Features to Find Success in Next Leg of ICD-10

How to avoid a billing system that will fail when more precise coding of claims are required, later this year

Dr. Seth Flam, CEO & President, *HealthFusion, Inc*.

October 1 2015 came and we all survived. Many providers are finding that their claims are being paid. But … we are in the honeymoon period. Remember, a few months prior to the start of ICD-10, CMS relaxed the claim submission standard. Instead of requiring the precise code, CMS mandated that all Medicare claims should be paid as long as the code was in the code family that matched the clinical finding – and most commercial payers have been following Medicare's lead.

The ICD-10 honeymoon period ends October 2016

Later this year, more precise coding of claims will be required. Many billing systems do not offer the additional tools to make the next leg of the ICD-10 transition work for your practice. There are three reasons that many billing systems will fail:

1) If the system relies solely on GEMs mapping
2) lacks support for appropriate code convention, like Code First and Excludes 1 and 2 and
3) implements an inadequate ICD-10 search tool. Find an EHR to offer you the following three features, and you'll find success in the new coding era.

1. **GEMs alone doesn't work**

If your current ICD-10 solution relies exclusively on GEMS mapping, your system will most likely fail later this year. GEMS (General Equivalence Mappings) are cross-walks between the ICD-9 and ICD-10 coding system. Providers are very familiar with the ICD-9 coding system, but not as familiar with the ICD-10 coding system, therefore many providers are still working off of ICD-9 codes and converting them to ICD-10. While thinking in terms of ICD-10 rather than ICD-9 is preferred, it will take a while for providers to have the same familiarity with ICD-10 as they do with ICD-9.

Currently, many systems are using the GEMS mapping alone to assist providers in making the conversion. This may work well to match to the family of codes but it does not work well enough to get the level of specificity that could be required beginning this October, including lateralization. With simple GEMS mapping there is no easy way to meet the very specific coding requirements that will be enforced later this year. In order to see success through the next juncture of the ICD-10 transition, **you need software with coding abilities that will help you find the more specific code required to match the patient's clinical condition to the most specific ICD-10 code, with a simple click on the appropriate stage.** The most specific code to describe the patient's clinical condition should be made available quickly and efficiently, and added to the claim.

2. **Support for Code First and Excludes 1 & 2**

CODE FIRST

ICD-10 has a coding convention that requires the underlying or causal condition be sequenced first followed by the manifested condition, which is referred to as the "code first" guideline.

Note this example:
H7201 - Central perforation of tympanic membrane, right ear

Your software should provide a **Code First alert** that warns the provider that code H7201 cannot be billed without an "any associated otitis media code" used first, these two code types must be billed together with the otitis media code used first.

EXCLUDES 1 & EXCLUDES 2 (content provided by Blue Cross of Michigan)
ICD-10-CM (diagnosis codes) has two types of excludes notes which are designated as Excludes 1 or Excludes 2.
– Excludes 1 means "NOT CODED HERE"

- The two conditions cannot occur together
- It is unacceptable to use both the code and the excluded code together

– Excludes 2 means "NOT INCLUDED HERE"

- A patient may have both conditions at the same time
- It is acceptable to use both the code and the excluded code together, when appropriate

Excludes 1 means "Not Coded Here"
The codes listed under the Excludes 1 note should never be used with the code listed above the Excludes 1 note.
Example: J03 Acute Tonsillitis

Excludes 1:

- acute sore throat (J02.-)
- hypertrophy of tonsils (J35.1)
- peritonsillar abscess (J36)
- sore throat NOS (J02.9)
- streptococcal sore throat (J02.0)

In this example code J03 – Acute Tonsillitis, cannot be coded together with any of the codes listed under the Excludes 1.

Your software should also give you exclusion alerts and provide exclusion tips.
Sample ICD-10 Tip:
*ICD-10 Exclusion Alert
J0301 – Acute recurrent streptococcal tonsillitis excludes the following diagnosis:

- acute sore throat (J)@.-)
- hypertrophy of tonsils (J35.1)
- peritonsillar abscess (J36)
- sore throat NOS (J02.9)
- streptococcal sore throat (J02.0)

This indicates that the code excluded should never be used at the same time as the selected code

When an Excludes 2 note appears under a code, it is acceptable to use both the code and any of the excluded codes that appear in the Excludes 2 note.
Example: M25.5 Pain in Joint
Excludes 2:

- pain in hand (M79.64-)
- pain in fingers (M79.64-)
- pain in foot (M79.67-)
- pain in limb (79.6-)
- pain in toes (M70.67-)

In this example code M25.5 - Pain in Joint, may be coded together with any of the codes listed under the Excludes 2. *Clearly we need to be much more aware of the Excludes 1 notes as they may lead to claim rejections*.

Real time Code First and Exclude code guidance during the ICD coding process is another must have feature. No one can remember every Code First and Exclude rule and therefore sophisticated software support for those complex sets of coding rules is the only way to avoid claim denials.

No one can remember every Code First and Exclude rule and therefore sophisticated software support for those complex sets of coding rules is the only way to avoid claim denials. Insist on a system that offers this level of support when considering the more stringent ICD-10 coding rules that will begin later this year.

3. **A sophisticated Search tool with the ability to find codes when you choose not to convert directly from a previously used ICD-9 code.**

"Any Word" search
Your ICD-10 search engine must perform searches in the same manner that Google does. This level of sophistication means that the order of the words should not cause the search to fail.

Example: H7201 - Central perforation of tympanic membrane, right ear

Your system should find the code even if the search is "perforation tympanic membrane central right," since you may not have enough familiarity with ICD-10 yet to order the search terms correctly. In fact, with MediTouch if you just knew that you observed a "perforation (of the) tympanic membrane," a sufficient number of codes would be returned almost instantly for you to refine your choice and lateralize to the appropriate code.

SEARCH BY ABBREVIATIONS OR COMMON TERM
Your coding system must also take into account that physicians often use common terms or abbreviations to describe a clinical condition. Some examples of abbreviations include; "CHF" for Congestive Heart Failure or "HTN" for Hypertension. Other times, ICD-10 may not use the common term. Take Morton's Neuroma, for example. In the ICD-10 coding world, no code is defined as Morton's Neuroma. Instead, the term is defined as "Lesion of plantar nerve." Your system must be able to map the common term to the ICD-10 term.

All of these "must have" advanced ICD-10 coding tools – **enhanced ICD-9 to ICD-10 mapping**, providing tips on **Code First / Exclusions** and a **"search friendly" functionality** – must be included in your billing system. Without them, physicians will inevitably struggle in choosing the most specific code that matches their patient's clinical condition. We are now in the honeymoon period and during this timeframe, payers will usually pay a claim if the code is close enough (in the same family). Remember, honeymoons don't last forever, though. Be sure your software has a set of features that will make ICD-10 coding work, even after this relaxed period. If not, it's time to find software that does.