ICD 10 Conversion, Coding Confusion, and Cerner’s Solution
Cerner Ambulatory solution cuts down coding and conversion confusion

A physician’s visit with a patient often centers on telling the patient’s story. Yet a physician’s revenue often centers upon properly documenting and coding that patient encounter. Studies have already shown that is difficult with the current International Code for Diseases (ICD) 9 used in the medical field in the United States. With the upcoming conversion to a much more complex ICD-10 coding method, the complications and need for correct coding will only increase.

Proper coding is a physician’s lifeblood. Without proper coding, a provider will not receive his or her proper reimbursement for his or her work. But consider a physician’s education. Most doctors are not taught coding, billing, or revenue cycles as an undergraduate, medical student, or resident.

“The most important thing is for us to really focus on what we do best,” said Delaware surgeon Isias Irgua, “without having to worry that there are going to be unresolved issues in the running of our practice. There is a lot going on behind the scenes when we take care of patients, be it issues in terms of the billing or in terms of dealing with insurance companies.”

Yet the vast majority of providers under-code their encounters, and therefore undercut the payments they receive. Take a recent ICD-9 coding study conducted at the University of Washington Medicine at the Seattle Cancer Care Alliance. Of the 209 notes examined, only one-third were coded accurately – and two-thirds were coded inaccurately. Of those inaccurate codings, 125 encounters were under-coded by one or two levels; 13 over-coded at least one level.

It should be noted coding is also a valuable tool for monitoring population health. The coding notes chronic diseases in an area, and outcomes associated with said diseases. “The buzzword is population health,” said Lisa Munn, Senior Strategist Analyst for ICD-10 with Cerner Ambulatory. “We need to know who, patient-wise, needs what, treatment-wise – so you can understand outcomes. Then, you can be proactive.”
The Centers for Medicare and Medicaid Services set the conversion date from ICD-9 to ICD-10 for October 1, 2015. The transition from International Coding for Diseases 9 to 10 brings several thousand more codes for physicians and/or their staffs to learn – and potentially bumble.

The ICD-10 codes are 7 characters long and may be numbers or letters, compared to the 4 or 5 digits of the current ICD-9 codes. As Munn explained, "in theory, it’s more specific. It gives everyone a better understanding of the outcome."

Note ICD-10 is also much more specific in diagnosing. For the below example, the ICD-9 code for a fracture of a vertebral column is 805.9. The ICD-9 code does not specify the location of the fracture. By contrast, the ICD-10 codes do.

As mentioned earlier, the new ICD-10 codes also help track outcomes. "Let’s say, for example, someone has a hip surgery," she said. "It’s been calculated it takes a total of seven visits for an optimal outcome. The provider gets paid $2,000. If it takes the patient 10 or 15 visits to reach the right outcome, the provider still gets paid $2,000. We’re trying to get more information into the systems, to help understand and even predict outcomes."

Thus coding – already complicated, as shown by the UW Medicine study ICD 9 study – now becomes more complicated. Already, there is a shortage of qualified coders in the medical field. Those in-demand coders will now have to learn the new ICD-10 system to be considered relevant in the industry. For those coders or staff members who are not proficient in ICD standards, the conversion learning curve will be steep. Audits
loom as budgets tighten in both the federal government and within health systems. Therefore, a physician’s chances of receiving the proper reimbursement diminish.

Cerner’s answer is Discern nCode, Cerner’s ambulatory evaluation and management (E&M) computer assisted coding solution. Discern nCode systematically reviews and codes physician encounter notes in seconds. It does not require additional coders or staff to re-read the documentation and code the information after the fact. Discern nCode also works in real time. The provider can continue his or her workflow without interruption and without a loss of reimbursement.

“nCode is a product that, in a sense,” said Dr. Jennifer Kay of Iowa, “reads your document and then tells you what E&M code it recommends you charge. It is based on the documentation you provide. nCode works because not all physicians are point and click doctors.”

For many physicians, the best part of the Discern nCode solution is its ability to capture non-discrete data. Some doctors feel dictation is a better way to capture the patient’s narrative, others prefer to type it into the Electronic Health Records (EHRs) as free-text. Most EHRs treat those dictations and free-text as images - blobs of text coding software often skips over. Staff must manually read the text after the fact, coding it by hand or risk losing revenue.

Discern nCode scans and codifies non-discrete data – so if a physician selects things manually, uses a template, uses dictation, or simply types in his or her documentation – it will be properly coded. “If you’re free texting and dictating, you’re not grabbing the data the same way, because the computer coding program couldn’t read that data,” added Dr. Kay. “So nCode is a solution that was developed to read that free text data or that dictated data – to pull out the pertinent bullet points that you need for your E&M coding. It’s a wonderful product.”
The above is an example of free-texting with Cerner’s Discern nCode. A physician may simply complete his or her documentation then sign the encounter note. That triggers the Discern nCode computer assisted coding review to begin.

Discern nCode’s physician eFeesheet first appears. With a few quick clicks, the physician chooses whether he or she had a new, established, or consulting encounter and what level of service the physician provided.

It also provides physicians with a coding summary and problem update list screen. This gives the physician a complete coding review, as well as information about the providers coding and documentation. Any changes or updates may be done at this time.

Additionally, the physician may compare the patient’s problems documented in the current visit with any problems in the patient’s active Problem List. This Problem List functionality streamlines the physician workflow and is also important for Meaningful Use.

Cerner’s Discern nCode solution provides complete transparency to all detailed coding – and it also provides recommendations. Cerner’s natural language processing technology parses complex medical terminology. No matter how the physician input his documentation, Discern nCode codes it. This gives a physician total transparency to all coding details, and recommendations. See the nCode Splitview screen shot below for an example.
In the UW Medicine Center study mentioned earlier, only one-third of physicians encounter notes were accurately coded. The study also introduced nCode into the same physician workflow. Discern nCode significantly increased the staff's coding accuracy. As one participant in the study said, "I like it a lot. I see how nCode codes it and I try to learn from that and code it better next time."
Improved coding accuracy ensures the physician is compensated appropriately for his or her work. Discern nCode provides tools and reports for both coders and auditors. They can quickly review E&M coding results on all physician documents for any period of time.

Using Discern nCode, coding teams can identify providers who need additional support on coding and documentation. It also provides tools to help educate new physicians. The coder workflow both audits and resolves any coding discrepancy within the system. This reduces the client’s audit risk in the future, and again, safeguards the physician’s revenue stream.

Ultimately, Cerner's Discern nCode solution safeguards a physician’s revenue while giving them coding confidence – and peace of mind. Now, a provider doesn’t dwell on the documentation dilemma at the end of a patient encounter, nor worry about the risk of revenue loss to his or her office. Instead, a doctor can focus on the reason he or she became a doctor – and practice medicine.

For more information about Cerner's Discern nCode solution:

CernerAmbulatory@cerner.com
800.927.1024
www.cerner.com