

5 COMMON
ICD-10
CODING
MISTAKES
& HOW TO AVOID THEM

The switch from ICD-9 to ICD-10 brought with it more codes, more complexity and unfortunately, more risk of coding errors. These mistakes are easy to make and can quickly wreak havoc on your practice.

Knowing what the most common coding mistakes are will help you avoid the headache that comes with rejected claims and delayed payments. In this guide you'll learn the five most common coding mistakes and what you can do to avoid them.

Being able to cut down on the number of coding errors is going to streamline your reimbursement process and help you ensure that your practice is efficient and more important, profitable.

5 Common coding mistakes & how to avoid them

Why coding is so hard

The medical community dodged another bullet with the recent announcement by the Centers for Medicare & Medicaid Services (CMS) that they're going to be more flexible when it comes to auditing claims.¹ The CMS was responding to American Medical Association (AMA) fears that the transition to ICD-10 was going to hurt a lot of practices. The switch to ICD-10 codes means practices are going from 17,000 codes in the ICD-9 system to over 140,000 with ICD-10. As a result, of the 15,000 Medicare claims that were submitted, one in five was rejected. "The likelihood that Medicare will reject nearly one in five of the millions of claims that go through our complex health-care system each day represents an intolerable and unnecessary disruption to physician practices," said clearly-frustrated AMA President, Dr. Robert Wah.

A combined report by the Healthcare Information and Management Systems Society (HIMSS) and the Workgroup for Electronic Data Interchange (WEDI) on the new ICD-10 system found that accurate coding happened less than two-thirds of the time.² An audit of hospital Medicare compliance found an average billing error rate of 49 percent.³ This just confirms what Wah expected, that accurate coding is hard to get right. The announcement also said the CMS wouldn't grant another extension; they're sticking to the October 1 deadline. This means that healthcare providers still have a lot of work to do to learn the new system so they can avoid audits, claims denials and penalties.

A combined report by HIMSS and WEDI...found that accurate coding happened less than 2/3 of the time.

¹ 7/6/15 CMS Press Release: "CMS and AMA Announce Efforts to Help Providers Get Ready for ICD-10"

² HIMSS, WEDI "ICD-10 National Pilot Program: Outcomes Report" 10/21/13.

³ Office of Inspector General, Office of Audit Service Hospital Medicare Compliance 2013.

Bad coding wreaks havoc on your bottom line

Inaccurate coding is one of the key barriers to receiving timely payment. Several reports predicted that, "The increase in claims denials and errors will cause substantial cash flow disruptions and a revenue shortfall for providers." Coding errors are easy to make and can quickly wreak havoc on your private practice. The cost is even higher when you consider the amount of time physicians will have to spend dealing with billing and coding problems. No one wants to waste precious time that could be spent with their patients to deal with the hassle of rejected claims as the result of coding errors. Simply put—inaccurate coding wastes time, money and affects your ability to deliver quality care.



The 5 most common ICD-10 coding mistakes

The most common coding mistakes range from the simple—mistaking a 0 for an O— to the more complex—using software systems that continue to use outdated codes. Knowing the pitfalls with ICD-10 coding and how to avoid them will be key to avoiding the mistakes that cost your practice precious time and money.

Top 5 ICD-10 Coding Mistakes

1. Transcription errors
2. Not enough detail
3. Using shortcuts
4. Bad software
5. Lack of training

#1 Transcription errors

According to *Becker's Hospital Review*, the top errors made by coders include simple transcriptions errors such as confusing the number 0 with the uppercase letter O and getting number 1 confused with lowercase L.⁵ Physicians and staff need to make sure that they don't make the same mistake. Take special care when dealing with these similar characters and when in doubt, crosscheck the code to make sure that it matches the diagnosis listed.

Many practices are starting to recognize the value of the latest Electronic Health Record (EHR) software) that can do the job for them. Your EHR should have automation and sophisticated billing technologies that can manage the new ICD-10 codes in a way that allows simple, accurate look-up and applications of codes in a busy clinical setting.

⁴ Grimsley J, O'Shea JS. "The New Disease Classification (ICD-10): Doctors and Patients Will Pay" 5/18/15. The Heritage Foundation. <http://www.heritage.org/research/reports/2015/05/the-new-disease-classification-icd-10-doctors-and-patients-will-pay>. Accessed 7/22/15.

⁵ "7 Common ICD-10 Errors for Hospital Coders." *Becker's Hospital Review*. Oct. 24, 2013.

#2 Not enough detail

Another factor affecting the accuracy of billing codes: not providing enough detail. The older ICD-9 billing codes were only 3-5 characters in length.

New ICD-10 codes are 3-7 characters and are much more specific. The Becker report found that coders may have used the correct diagnosis code, but didn't provide the procedure code. They may have listed chest pain, but failed to indicate the type of chest pain. The HIMSS report found the same problem of not enough detail: "Pain in limb" was coded accurately only 33 percent of the time because specificity and laterality—both major components of ICD-10—were not included.⁶

Coding staff is going to have to spend a little extra time making sure that their coding is as specific as possible. You might need to consider additional support to tackle the job. EHR with the latest ICD-10 codes can dual code and test through with your payers. This type of functionality is going to help you avoid the rejected claims for not providing enough detail.



#3 Using shortcuts

Holt Anderson, Executive Director at the North Carolina Healthcare Information and Communications Alliance, said that with the switch to ICD-10 providers reported a 50 percent decrease in worker productivity and an increased error rate when submitting claims.

“Even the best coders were accurate only 50% of the time and it took almost twice as long to code using ICD-10 codes.”

Even the best coders he said were accurate only 50 percent of the time. Anderson also reported that it took almost twice as long to code.⁷ As a result, coders are taking shortcuts like referring to “cheat sheets,” memorizing codes, or using Internet search engines. In her article, “Beware of Poor Coding Habits,” Susan Chapman cautions against poor coding habits and reminds coders to rely on more reliable, established resources like reference books and software programs.⁸

Let's admit it—coding is a hard job, but your staff doesn't have to go it alone. Some EHR software systems offer convenient apps that perform a number of tasks that can lighten the load. Look for technologies that offer time-savers like tracking your progress for the switch from ICD-9 to ICD-10, comparing ICD-9 codes with ICD-10 equivalents, and quick search/code look-up options. Getting an automated system to help overworked staff is going to save you from those dreaded claims rejections and increase your front office productivity

⁶ Herman B. “Report: Only 63% of ICD-10 Documentation Accurately Coded”. *Becker's Hospital CFO*. 10/24/13.

⁷ MGMA 2013 Annual Conference

⁸ Chapman S. “Beware of Poor Coding Habits”. *For The Record*. January 2014.

#4 Bad software

Not all EHR systems are created equal. There are many programs out there that aren't up to date.

Practices with out-of-date software are going to run into problems with their coding and increase the risk of rejected claims. Choose a system that has already made the changes necessary for the switch to ICD-10. That means importing the new codes, dual coding, and testing. Make sure you choose a cloud-based EHR and practice management system that can be automatically updated at no extra expense.

Your private practice shouldn't have to budget for system upgrades. If your vendor isn't providing adequate resources to help you prepare for the switch, it might be time to look for a new EHR.



#5 Skipping training

Many coding mistakes are simply the result of not getting enough training. A recent WEDI survey revealed the lack of readiness among healthcare providers and that the lack of progress is cause for concern.⁹ Practices can't afford to wait anymore, so small practices are looking to their EHR vendors for help. A recent *Medical Economics* article, "ICD-10 documentation:

The key to getting paid," described how independent practitioners who can't afford the luxury of dedicated coders are turning to vendors for help.¹⁰ They recognized that top EHR vendors can provide training modules, webinars, and guides to make sure their practice is trained and ready for October 2015.



⁹ McCann E. "WEDI survey: ICD-10 readiness still underwhelms." *Healthcare IT News*. 4/6/15. <http://www.healthcareitnews.com/news/wedi-survey-icd-10-readiness-still-underwhelms>. Accessed 7/22/15.

¹⁰ "ICD-10 documentation: The key to getting paid." *Medical Economics*. <http://medicaleconomics.modernmedicine.com/managed-healthcare-executive/news/icd-10-documentation-key-getting-paid?page=full>. Accessed 7/22/15.

Conclusion

Most medical practices experience coding errors leading to rejected claims, delayed payments and more work for your office. But there are steps you can take to decrease the number of coding errors your office makes—even during the ICD-10 transition. Take note of these five common coding errors and make sure your practice is ready with the best coding technology and processes available. By implementing practice management software and an EHR that offers you the most advanced coding tools, you can reduce coding errors, protect your bottom line and ensure a healthier private practice.

Learn more about how AdvancedMD EHR capabilities can work for you

The ICD-10 experts at AdvancedMD have the solutions you need to avoid costly coding errors and prepare your practice for the switch. AdvancedMD is the perfect partner for you in both ICD-10 conversion and EHR implementation.

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