5 QUESTIONS TO ASK YOUR EMR VENDOR TO ENSURE ICD-10 READINESS

Assigning ICD-10 diagnosis codes for ED patients becomes mandatory October 1, 2015. As you probably know, this new code selection regime mandates the assignment of more specific diagnosis codes based on enhanced descriptions of the pathology and condition. This means that providers and their scribes will need to document aspects of a patient's illness or injury that they may not have included in the record before. One of the first steps to ensuring that your medical record contains all the components necessary to assign an ICD-10 code is to make sure your EMR currently has, or will be updated soon with, the right tools to prompt your providers to input this new information. Now is the time to consult with your EMR vendor to verify. To assist you in this conversation, below is a list of questions that will hone in one the ED-specific documentation changes that commence October 1.

1. **Does the EMR either prompt or allow a provider to document the following major categories of newly required information under ICD-10?**

    - the laterality of a condition or illness
    - the episode of the encounter
    - whether the diagnosis is acute or chronic
    - the obstetric trimester for pregnant patients
    - certain anatomic descriptions for specific injuries or illnesses (discussed in more detail below)

2. **Does the EMR prompt your providers to note 1) abornamlities in labs reviewed, 2) the stage severity of certain illnesses or 3) complications related to a primary diagnosis?**
   Noting each of these factors will be critical to ultimately assigning the correct ICD-10 code. Below are some examples of these documented features:

   Examples of severity:
   - Chronic Kidney Disease staging (1-5, ESRD)
   - Ulcer staging (stage I-IV)
   - Burn degree, extent of total body surface area and percent of third degree involved

   Examples of significant lab:
   - Dehydration with abnormal serum creatinine
   - Hypoxia or hypercapnia with asthma or acute respiratory failure

   Examples of disease complications:
   - Primary or secondary diabetic with nerve/kidney/circulatory manifestations
   - Influenza complicated by pneumonia
   - Febrile Neutropenia due to chemotherapy, HIV
   - Angina secondary to uncontrolled hypertension

3. **Does your EMR prompt a provider to note co-morbitidies for admitted patients?**

   Be sure to include clinically significant co-morbidities in your diagnoses for patients who are admitted. This will help in documenting conditions that are present on admission ("POA") indicators. POA is defined as "present at the time the order for inpatient admission occurs". The purpose of the POA indicator is to differentiate between conditions present at the time of admission, such as pressure ulcers and catheter related infection, from those conditions that develop during the inpatient admission.

4. **Will the EMR remind providers to furnish the new anatomical descriptions for certain common ED injuries or conditions?**
   ICD-10-CM supports much more precise anatomic description of the injury or condition. Simply stating "pneumonia" or "ankle sprain" may be inadequate. While many of these descriptors were present in the older system, they are more prominent and enhanced, such as laterality, with ICD-10-CM. While it's unreasonable to expect the EMR to walk a provider through every potential ICD-10 code, the program ideally would remind providers to include new documentation components for certain commonly injured areas or commonly treated illnesses. Below is a sample of specific items that will need to be documented:

   - Laterality - Right/Left/or Bilateral
   - Arm or Leg - Upper or Lower/Proximal or distal
   - Hand - document individual metacarpals
   - Foot - document individual metatarsals
   - Fingers - specify which fingers are involved, avoid using numbers
   - Phalanges - document whether proximal, mid, or distal phalanges
   - Toes - document which toe(s) and joint(s) are involved
   - Face - document whether upper or lower eyelids and lips
   - Pneumonia - specify whether right, left, or bilateral)
   - Abscess/Cellulitis – document the precise anatomic location

5. **Does the EMR prompt the provider to include new pregnancy-related documentation?**

   Most pregnancy codes in ICD−10 have a final character indicating the trimester, so this will need to be documented. A provider will also need to document whether the patient's condition is or is not impacting the pregnancy (otherwise coders default to a complication).