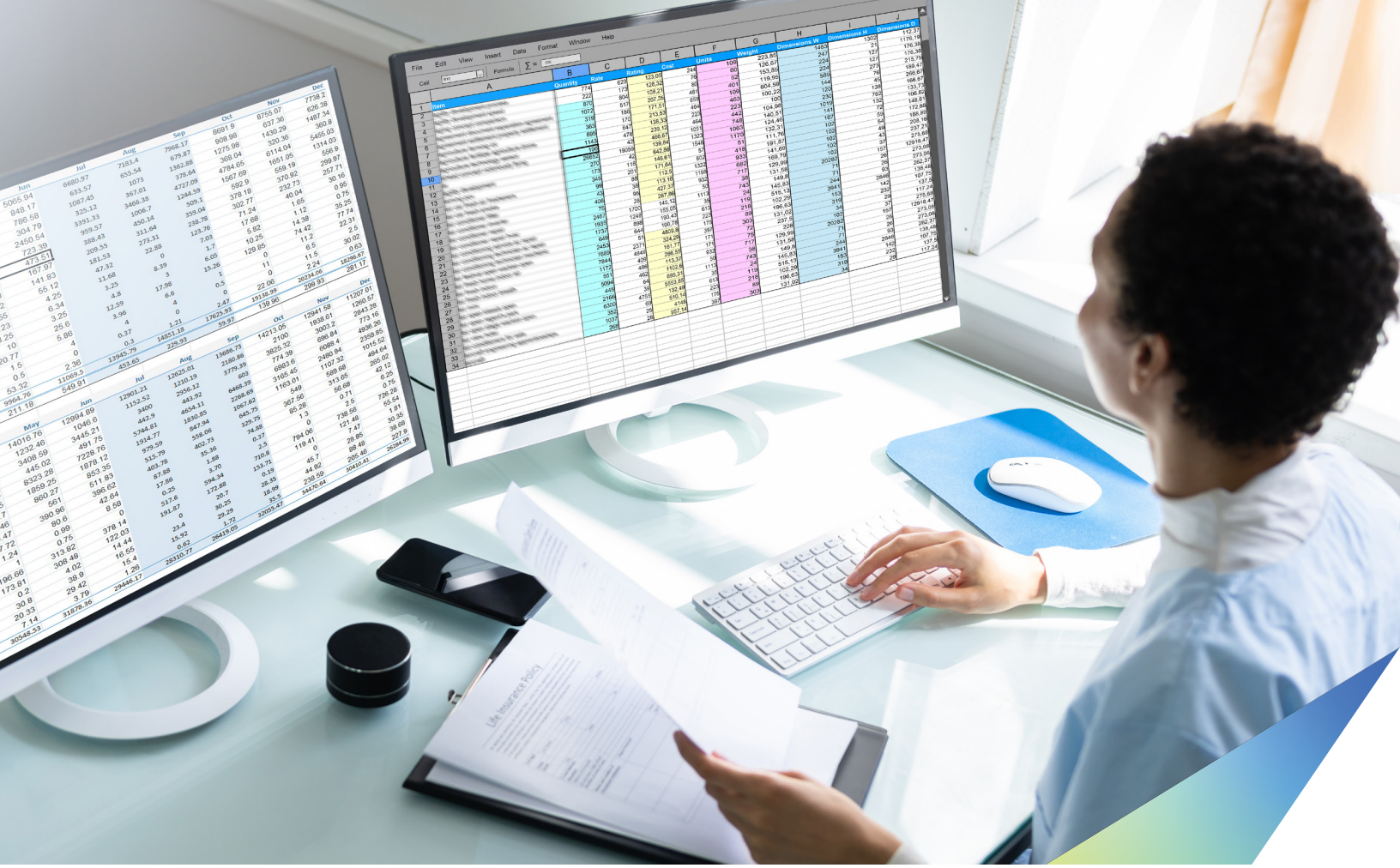

Healthcare

5 Coding challenges that can make or break a healthcare organization's financial future

By Cognizant RCM editorial team

An organization may be buttoned up from the time the patient walks in the door, but what happens after the encounter will determine when the practice will get paid. This element of the revenue cycle starts with coding. Here are five medical coding challenges that will ruin your bottom line.

Coding to the highest specificity

Missing data on a claim relative to the patient's diagnosis and procedure can easily cause a rise in denials once received by the payers, resulting in potentially thousands of dollars in write-offs.

Medical coders are responsible for coding patients' claims to the highest level of specificity, ensuring the appropriate CPT, ICD-10-CM, and HCPCS codes are applied based on the patient's chart from the day's services.

Previously, The Centers for Medicare & Medicaid Services (CMS) would bring on new diagnosis codes and code sets, delete codes and revise codes yearly,

with different variations and modifiers to add to the complexity. Historically, medical coders would spend a lot of time researching and learning new codes, only to discover annual changes and updates have been made to keep pace with the ever-changing landscape of healthcare. Furthermore, in 2022, CMS announced that instead of annual updates to ICD-10-CM and ICD-10-PCS, these code sets will now be updated twice a year, in April and in October. The 2023 ICD-10-CM updates for April alone included 42 new billable healthcare codes, with changes in many areas, including head injuries, dementia, maternal care and pregnancy. Payers don't only want to know the diagnosis and the treatment; they want to know the cause as well. Of the 42 code additions, 14 of these are new to help better identify adverse social conditions that negatively impact health or healthcare. Being able to stay on top of codes specific to the patient's diagnosis at treatment is more difficult than ever before.

In addition to code sets being updated periodically, correct code assignment to the highest level of specificity is dependent upon provider documentation. For example, there are numerous ICD-10-CM code categories that require laterality or specificity of digits. If the documentation does not indicate this required information, a diagnosis code may not be able to be assigned at all or will need to be assigned an unspecified code. As stated previously, unspecified codes can result in denials. A coder query process and Clinical Documentation Improvement Program (CDI) can be critical components to obtaining the required clinical documentation/information. Inpatient, as well as outpatient CDI programs, are resulting in improved coding and reimbursement and decreased denial rates.

Upcoding

While code specificity is important, so too is ensuring the claims do not contain codes for exaggerated procedures, unbundling of procedure codes, or even procedures that were never performed, resulting in reimbursement for false procedure(s). This seems logical enough, but upcoding can easily occur as a result of human error, misinterpretation of a physician's notes, or lack of understanding of how to appropriately assign the thousands of ICD-10-CM codes in existence. To add to the pressure, the Office of the Inspector General has issued a plan with objectives to prevent fraud and scams, and remedy misspending of COVID-19 response and recovery funds.

Much like under-coding, or not providing enough data on the patient's visit, can create issues, upcoding can be a major contributor to financial loss for a practice. Questionable claims can be denied and sent back for corrections and appeals, but upcoding can have more serious ramifications outside of paper pushing between coders and payers. Whether it's making sure the codes are in accordance with the care provided, understanding the code sets that apply for each procedure, comprehension of the medical record, or navigating through the 2023 Evaluation and Management guideline changes, refraining from upcoding will help deliver a sturdy and compliant revenue stream.

Missing or Incorrect Information

There is a common theme to coding challenges, and that is having sufficient information necessary for complete and accurate coding. This data is typically pulled from a patient's chart or record for a billable visit. This information is often completed by the attending physician, but other providers' documentation may be incorporated. Even when a claim has been made, it is still critical to give the payer the pertinent procedure information. Situations such as failure to report time-based treatments (such as anesthesia, pain management or hydration treatments) or reporting a code without proper documentation can result in denials.

Additionally, information in a patient's electronic health record may also contain inaccurate information. When documentation is precise and thorough, it helps convey a patient's narrative and may even enhance patient care. However, errors or inconsistencies do happen as part of human nature. It turns out that a number of factors, such as time restrictions and compliance woes, can contribute to the generation of poor documentation. Keystroke errors and other human errors can cause these situations to flare up,

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and it takes a diligent, thoughtful coder to thoroughly read the medical record and ensure claims contain the appropriate information.

Timeliness of coding

The Medical Group Management Association (MGMA) suggested in their 2018 Setting Practice Standards report that a Primary Care Physician should maintain a claim submission rate of 3.11 days after the date of service, but it is becoming increasingly difficult for practices to uphold anything close to this rate. Constant changes to code sets, increased focus on submitting claims with sufficient and compliant information and being required to code claims to the highest level of specificity can easily delay the submission by days or weeks.

Nevertheless, delays in coding and submitting claims can cause major lags in payment and substantial loss in revenue. Insurance payers have statutes of limitations that require claims to be submitted anywhere from 365 to just 60 days after the date of service. Simply put – the more time spent coding the claim, the later it will be submitted, thus increasing the odds that the claim will be denied. Expert coders are aware of this and do everything in their power to get coded claims out the door.

Staffing shortages

Finding experts well-versed in coding claims quickly, accurately and in compliance with the False Claims act is not always an easy task. The U.S. Bureau of Labor Statistics estimates that the demand for medical record specialists and coders will grow at an annual rate of 9% from 2020 to 2030. As one can imagine, the increasing need for care within the senior population is causing a rise in claim volumes, and trying to find a team of coders who know the ins and outs of complex ICD-10, CPT and HCPCS coding can easily cause a bottleneck in the revenue cycle. Health executives expressed their struggles to find talent as far back as 2015, and some forecasts expect a decline in commercial payments by 2024 to further hamper a C-suite's ability to manage labor costs. The ramifications of incorrect coding is still a key topic of discussion to this day.

A coding mentoring program is a great way to get interested internal administrative or billing employees trained for well-paying coding positions with opportunities for advancement within the HIM team. By utilizing internal or external coding mentors, a coder development program can be created. Coding consultants can provide coding instructional materials, training on official guidelines and coding sample charts with concurrent feedback to help your coder trainees become proficient inpatient, outpatient and profee coders. Those already skilled in one area of coding, such as outpatient, can also be cross-trained to become skilled across multiple specialties.

Hospitals and health systems are also searching outside of their organizations for help with tackling the coding conundrum. When looking for coding support, what are some criteria providers must look for in partner organizations in order to sustain efficiency and accuracy? An arsenal of highly skilled, well-trained AAPC & AHIMA certified coders is just the beginning. A wide breadth of experience that will result in getting the details right the first time, however, is something that cannot be taught. Starting with an evaluation of your current processes against the challenges above and identifying any gaps is a great foundation in keeping up with the constantly evolving coding environment and reducing revenue loss from coding errors.

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