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The Changing Face of Healthcare Coding

By Robert Freedman

Many institutions' compliance departments are joining forces with revenue cycle under a new banner, "Revenue Assurance." Compliance departments are facing a growing array of regulatory recovery programs, with the same or fewer resources to ensure correct coding. The recession has hit healthcare hard; finance departments need to optimize the revenue cycle. With resource constraints in both departments, there is an opportunity for finance and compliance to collaborate to help their organization obtain the correct reimbursement for services rendered.

Capital Health in Trenton New Jersey has common ground for its Finance Department and Corporate Compliance Program – to get paid without errors. Stephen Miller, JD, serves as Chief Compliance and Privacy Officer. He oversees a program that promotes system-wide compliance with applicable laws and regulations, especially those related to federal healthcare program participation. Miller says that the Compliance Program helps provide the Finance Department with a valuable product: 'Revenue Assurance.' By improving controls and reducing the opportunity for violation of payment rules, the program supports the finance function, which requires some level of assurance that it won't have to return payments received. Compliance supports finance with quality audits that improve the percentage of retained revenue.

To see the opportunity clearly, let's take a step back and talk about the revenue cycle. Good revenue cycle management (RCM) is crucial in healthcare, which has so many moving parts between the patient visit and reimbursement. Even in organizations that have a focus on RCM, hours of time and expense are spent trying to recoup monies long after the patient leaves.

The revenue cycle begins when the patient schedules an appointment. After scheduling, there is registration, an area of the revenue cycle that is ripe for error such as data entry errors, missing fields, missing referrals, etc. After registration is the actual patient visit. Services provided must be captured using a coding system that continues to get more complex – and will undergo a huge change with ICD-10 code sets. These codes are captured on the encounter form.

The encounter form is often in the hands of staff whose function does not include understanding coding or clinical procedures. In some cases, they will key the data directly into the billing system. Other times, the encounter forms are batched, co-pays calculated and the daily work is sent to central billing. In the billing department, documents are sorted, money deposited, and the encounters are handed to data entry or billing staff, most of whom are trained in billing, but not coding.

Sometimes coders get involved before the encounters are routed to billing, but not always. Instead, healthcare often depends on software to pick up basic errors and route the claims back to billers to fix before they are sent to the insurance company. However, the software only picks up the errors that the billing management has turned on. To work adequately, the system needs to review the billing history of an individual patient. Most offices turn this function off because it bogs down the processing. At the end of all these inputs and activities, coders work the claims. Clearly, this is not a particularly efficient process.

James Taylor, MD, Medical Director of Revenue Cycle at Kaiser Permanente Denver, has coined the phrase "rescue and recovery" to describe the function of the coding process described above. "Most coders' primary role is to rescue the claim before it leaves the doctor's office by adding correct codes, modifiers and other essential coding elements to ensure an accurate claim," says Taylor.

When the claim leaves the facility, it must then get through the insurance plan's edits. Here, the claim is either denied, rejected or paid (in full or in part). The denials, non-payments, and rejections from the payor must be individually researched and fixed for resubmission in a certain amount of time, i.e., timely filing.

An exorbitant amount of time is spent "working down claims" in healthcare. Yet, this does not resolve the root cause of the problem. It does not prevent the same mistakes from happening over and over again.

Physician/clinician education is one way to battle the incorrect claim. Dr. Taylor brings this a step further. He believes – and has seen success with – bringing the coders from the end of the revenue cycle to the beginning. According to

Taylor, “coders need to leave their world of rescue and recovery coding and transform their paradigm to being an upstream auditor/educator.”

Some successful models utilize not only one-on-one education sessions, but also a project management approach to the process. The objective is to develop an encounter form that truly represents the business of the provider. Whether this is still a paper process or an electronic process is not as important as realizing that developing an accurate encounter form is not simply placing codes on the document. It requires the expertise of a skilled coder, who understands the clinical aspect of the physician work and the payment rules that drive the use of codes.

Taylor explains that accuracy and completeness drive clinical registries and also optimize revenue. “We needed to incorporate into our solution the concept of completeness of documentation. In an EMR, many procedures are dictated or typed into the body of the progress note, but they must be entered also into a codified field so that the data will flow to a claim. Initial audits three years ago revealed we left as much as 20-24% of procedures buried in the body of the note. Good care, good documentation… but not adequate for charge capture,” says Taylor.

Dr. Taylor discusses monitoring of the process for Kaiser Permanente and the use of a software product called MDaudit. “This has been a significant factor in timely turnaround.” Using an Access database and less sophisticated tools, his cycle times at KP were over 60 days. “We had to manually determine which charts to audit, find the appropriate number of codable notes, develop our own audit findings tool, put this into an Access database and then write our own reports” says Taylor. “We are an excellent health care company. Chart pulls, audit finding entry and tracking, reporting and data storage are not our core competencies. Implementing MDaudit has cut our cycle time from over two months to well under two weeks. Our providers can now get feedback on cases they actually remember coding, as it was a patient from last week or the week previous. Although there are competing auditing software products out there, we chose MDaudit as it was used by many leading institutions such as John’s Hopkins, Duke, UCLA and other well respected institutions,” says Taylor. “Using coders in an upstream auditing and educational role was crucial to the success of attaining 95% accuracy in coding and claims accuracy in Kaiser Permanente Colorado.”

Education, at the heart of the revenue cycle management process, is key to a successful RCM program. According to Steve Miller, “If you find issues two years after being paid, in many cases you lose that revenue entirely. At best (as in the case with RACs) you have to give back at least a percentage of that revenue. Capital's corporate compliance program has ‘active monitoring’ in place for key compliance areas such as coding, billing and documentation. The review may not cover every case but spot-checking high-risk areas (e.g., checking every 5th claim). Similar to a manufacturing line, this process takes place in most departments, especially in key compliance risk areas such as patient access, coding and patient accounts.”

Even if an organization is performing concurrent utilization review, Miller believes compliance audits still need to be conducted. “There are areas in which judgment is needed, such as medical necessity for a short stay,” says Miller. “We look for patterns, and system breakdowns, and then fix the underlying problems.”

Combining the professional coding resources of these normally siloed departments has proven to be an effective approach to improving billing quality. Dr. Taylor notes that through this process, not only did Kaiser Permanente achieve 95% accuracy, but also an unexpected benefit of a 28% reduction in workforce within the ranks of professional coding. By shifting the workload distribution from 90% "rescue recovery" to 60%, and increasing the number of "audit educators,” KP has witnessed fewer cases requiring the additional steps that traditionally consumed the resource.

In the post reform era, the concept of “revenue assurance” presents healthcare organizations with an opportunity to better utilize a valued resource – their coders. Coding is the translation of patient encounter documentation to the payable form – the claim – which is the lifeblood of the industry. Healthcare is ready to exercise 20th century quality management processes to detect and remediate the causes of denied and underpaid services. Moving the effort closer to the source is not only cost effective, it assures more accurate documentation, which translates to patient safety. Lower costs, better use of resources, accurate reimbursement, patient safety… there is much to gain from a simple reassessment of our processes.

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